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MADNESS, LIBERTY AND THE LAW

Is the Law Justified in Using Madness to Limit Liberty?

by

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ABSTRACT

We are in an era of self-conscious minorities forecfully asserting their right to have rights in accordance with the Constitution and the Bill of Rights themselves.

This paper explores the rights of those committed to psychiatric treatment for disturbed and disturbing behavior. The large question is the subtitle: Is the law justified in using madness to limit liberty?

The antagonist is Doctor Thomas Szasz, psychiatrist. He maintains that mental illness is a myth and that social engineering by psychiatrists is subverting the law and perpetrating injustice on those labelled mentally ill and dangerous to self or others.

The body of argument is built on the skeletal framework provided by the assertions of Dr. Szasz. Personal experience and interpretation, supporting data of various kinds, interviews and conversations and the views of various authorities are marshalled to show that, in the opinion of this writer, Dr. Szasz is fundamentally mistaken in his basic position.

The paper concludes with several recommendations that, it is believed, will improve a just and necessary North Carolina law, the intent of which is to safeguard the liberty of individuals and of society.

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MADNESS, LIBERTY AND THE LAW

Is the Law Justified in Using Madness to Limit Liberty?

A THESIS
PRESENTED TO

THE FACULTY OF THE
DEPARTMENT OF POLITICAL SCIENCE
IN CANDIDACY FOR THE DEGREE OF
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by

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CONTENTS

LIST OF FIGURES

LIST OF TABLES

PREFACE

"You're mad!" is a phrase that most of us have used or had used against us. Its convenience is obvious: it dismisses the accused as "sick in the head" and therefore, to be treated as an irrational antagonist. This allows the accuser to proceed without regard to the arguments of the other. Conscience is salved, guilt feelings are prevented, prejudice is undeflected, and the original goal can be pursued.

Institutions and professions have prospered or been maintained because of society's need to have some of its members proclaimed mad by judge or jury. Is this good or bad, right or wrong, helpful or harmful? More specifically, it can be asked:

1) Does this practice benefit the accused?
2) Is liberty extended or preserved for the accused?
3) Does the Rule of Law give way to the Rule of Men when institutions question someone's sanity?
4) Do moral, ethical, and medical values replace those of jurisprudence when the courts enter

the realm of psychology?

5) Are philosopher-kings created to displace juries of ordinary men and women who listen to the testimony of psychiatrists and other mental health professionals?

6) Do mental hospitals become prisons after a declaration of insanity or incompetency?

7) Is madness treatable and is the treatment of madness an enhancer of liberty?

We need to take a fairly long journey even to be in a position to understand the questions. As the questions take on meaning, the answers will materialize, not in objective certainty, but within one's general philosophy. The goal of the author is not to divert or convert but to provide the matter out of which the form of answers can take shape. Each citizen has to make an intelligent decision about many things, two of the most important of which are liberty and mental health. Do we want liberty or mental health? Can we have both? Do we want one at the price of the other? Is legislation creating a therapeutic state? or are individual rights being preserved at the expense of health and the ability to cope with complex challenges?

One question generates another; answers point the way to more questions. This inquiry about madness, liberty and the law will aim at supplying the information for each reader to answer intelligently for himself whether madness

(mental/emotional distress or disorder) is treatable and whether the treatment is a destroyer of liberty. If that position is gained, the reader is in a position to deal more effectively with the many other questions that need answering.

Appendices A--E and G describe the present resources of the mental health establishment in North Carolina and in Forsyth County, in particular. They reveal the capacity of the mental health system to respond to the legislative mandate to provide expanding forensic services at the local level. They provide foundational and background material (if the reader need to become acquainted with it), so one can analyze case studies and the very strong and long-standing position of Thomas Szasz, M.D. Dr. Szasz, like and Old Testament prophet, has been trying for more than twenty years to show that we are building a therapeutic state, providing mental health at the expense of liberty. The concluding chapter will try to set the stage for unravelling the questions and knowing whether answers are possible or not.

This paper is primarily concerned with the commitment process of a person certified by a physician as mentally ill or inebriate and imminently dangerous to self or others, but who is charged with no crime. There will be many references in this paper to the criminal justice system and its defendants charged with felony or misdemeanor who alwo show signs of mental illness. These inclusions will provide a framework of reference for better assessing the commitment process in which a legal crime is not charged, but may de facto be present. As

we will see, some prominent authorities have claimed that the court should deal only with those who have broken the law and not concern itself with the treatment of the mentally ill.

This author writes from a perspective of ten years of pastoral ministry, six years of community organization among the economically and culturally disadvantaged (or oppressed), and four years as a mental health center counselor and program director.

INTRODUCTION

The Community Mental Health Center (hereafter referred to as CMHC) is the usual entry point for the psychiatric evaluation of commitment cases which come before the judiciary. Besides the power to commit, the judiciary has the power of subpoena to command mental health professionals into the legal drama of the court. The state legislature has passed laws that command the services of public mental health professionals for the evaluation and treatment of committed patients. The link-up of the mental health, the judicial, and the law enforcement agencies of the state is complete and mutually dependent.

In his book, Law, Liberty, and Psychiatry, Thomas Szasz, M.D., writes in the Preface: "Psychiatric activity is medical in name only. For the most part, psychiatrists are engaged in attempts to change the behavior and values of individuals, groups, institutions, and sometimes even of nations. Hence, psychiatry is a form of social engineering. It should be recognized as such."

This is a formidable accusation. It casts a preeminent profession in the role of a manipulator, the direct

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[1]Thomas S. Szasz, Law, Liberty, and Psychiatry (New York: the Macmillan Company, 1963), p. vii.

opposite of its avowed purpose, that of helping, or serving the health and well-being of a person.

He states, also in the Preface, that his book has two aims: "...first, to present a critical inquiry into the current social, and especially legal, uses of psychiatry; second, to offer a reasoned dissent from what I consider the theory and practice of false psychiatric liberalism."[2] He claims that in mental health legislation, "There lurks the danger of tyranny by therapy."[3] He will try to show that psychiatry in the United States is "All too often used to subvert traditional guarantees of individual liberty."[4]

This is a large matter in itself and of special import to the mental health profession of which this writer is a member. Accusations of false liberalism are one thing: accusations of "tyranny" and "despotism" and "subversion of liberty" are another.

Thomas Szasz has made long, loud and clear objections to the way psychiatry has danced to tne legal profession's and state legislature's tunes in which he feels liberty gets lost in the name of therapy or mental health.

The big question is involuntary commitment---the question of dangerousness at the time behavior in the community is considered bizarre and threatening as the result of mental illness or inebriety.

We are now ready to join the issue. tack will be to consider the arguments of Thomas Szasz, M.D., on in-

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[2]Ibid., p. vii [3]Ibid., p. viii. [4]Ibid., p. viii.

voluntary commitment as presented in his book referred to above. His charges, stated positions, reasonings and conclusions will be consdiered in the light of this writer's experience and basic philosophy. The bases for this writer's evaluation and conclusions will be: evidence offered by actual cases in the files of the mental health center; on the arguments of authors referred to in the text; on his own experience as a mental health counsellor and administrator; and on his personal convictions or philosophy about public policy and life in the modern community.

The final chapter will be an attempt to give tentative answers and directions to the questions presented in the Preface.

CHAPTER I

MENTAL ILLNESS: IS IT A MYTH?

Unless one heard the question asked, it would probably never occur to most people. All the mental health centers and associations, with their voluminous literature and public relations, indelibly ingrain us with the existence of mental illness as the enemy they are fighting. Yet Thomas Szasz asks the question.

In Chapter I, "What is Mental Illness?" of his book, Law, Liberty, and Psychiatry, Szasz recapitulates the substance of his former book entitled, The Myth of Mental Illness[1]. It is necessary to appreciate his position on this question in order to follow and assess his convictions on forensic psychiatry.

Szasz says that first, we must realize that there is no universally acceptable definition of mental illness, or even of mental health. Mentall illness is an enigmatic condition that allows each age, each profession, each professional, to define it, for one's own best use. Mental illness is not an objective thing. It does not exist in itself, apart from an acting subject. What is called mental illness is an overt behavior or expression existing as an attitude

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[1]T.S. Szasz, The Myth of Mentall Illness, Foundations of a Theory of Personal Conduct. (New York: Hoeber-Harper, 1961).

or a relational position vis-a-vis the world and self that is seen by others as inappropriate and unacceptable.

Szasz goes on to say there are diseases of the brain, like that which derives from syphilis or severe intoxication. But these are not diseases of the mind, mental. One school of thought maintains that all mental disorders may be traced to pathology of the brain and the neurological network. It would deny that people's troubles can derive from the problems of living, like facing conflicts in values, opinions, social aspirations, personal needs, etc. This school sees bodily disease, with its symptoms, as directly comparable to mental disease and its own symptomatic manifestations.

Szasz sees two fundamental errors in this school's position.[2] The first is that a disease of the brain is a neurological defect, not a problem in living. A person suffering from severe, long-term memory loss or epileptic seizures is suffering from definite lesions in the brain or the nervous system. But is a person claims belief in Communism or Christianity, or says that his internal organs are rotting, it cannot be explained by a defect or disease of the nervous system or brain. Explanations of this sort or occurence must be sought along different lines.

The second error Szasz finds is an epistemological one. There is a failure to distinguish the ground on which one is diagnosing. Medical illness is judged or diagnosed

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[2]T. S. Szasz, Law, Liberty, and Psychiatry, An Inquiry into the Social Uses of Mental Health Practices (New York: MacMillan Co. 1963), pp. 12-13.

on objective, scientific facts, observed and tested. Mental illness is judged on the basis of one's own conceptions of values, history, happiness, acceptable behavior patterns, success, goals, means, and the like. There is no analogy, Szasz maintains, between these two kinds of symptoms and their source, and therefore, he says, the common word, "illness" cannot be applied to both cases in the same way.

Another way of viewing mental illness, says Szasz, is as a deformity of the personality and the cause of deviant behavior in interpersonal or social relations. This is very faulty reasoning, in Szasz' view: it makes the abstraction, "mental illness" into a cause; it is nominalism---making a thing out of a name.[3]

The whole concept of illness, Szasz continues[4], whether bodily or mental, points to a departure from a commonly and scientifically accepted norm or standard. The structural and functional integrity of the body is a clearly acceptable physical health norm, agreed upon by most people. But what is regarded as mental illness? The norm has to be of a psychosocial and ethical nature. But who decides the mental health norms and who decides the mental illness deviations? Why is it that psychosocial and ethical concepts of deviation from a subjective norm can have medical remedies prescribed?

The import of this confusion over what mental ill-

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[3]Ibid. pages 13-14.

[4]Ibid. p. 14.

ness is, leads to many practical and philosophical difficulties that according to Szasz, produce injustice and suffering.

Szasz concludes the chapter by stating that the concept of mental illness has outlived any useful purpose it may ever have had. It is now only a convenient myth. The term is but a metaphor mistaken for a fact, and should be dropped from our lexicon.

CHAPTER II

THE MYTH MISSES THE POINT

This writer agrees and disagrees with Dr. Szasz. Agreed that mental illness, when equated with bio-medical illness, is a myth and a misuse of words. There are organically based mental-emotional disorders which would qualify under the disease model of physical medicine, and with these, apparently, Szasz has no quarrel. But, it is not agreed that the use of the term "mental illness" is the base on which rests all the miscarriages of justice concerning the citizen who becomes immenently dangerous to self and others and is mentally ill or inebriate.

Thomas Szasz takes the radical position that the concept of mental illness is a pure fabrication, a myth, that should be eliminated and that involuntary commitment, which is based on the use of the concept, should go with it. His foundation for that stand is the right of any human being to make his own decisions about the short and long range course of his life. As long as the myth is current, he maintains, the excuse for depriving people of their liberty remains in force.

I join Szasz in the assertion that mental illness, as a technical phrase or term, should be abolished, but only when we can find a universally acceptable and properly under-

stood substitute, I do not agree that we can eliminate the concept behind the term, or limit concern to the organically based mental troubles people suffer, or, finally, that we can eliminate the commitment practice that strives to protect individuals and community alike from the danger of someone who is out of control of his behavior.

There are no simplistic explanations of the origins of mental and emotional disorder or disequilibrium or incompetent coping or whatever else is called, "mental illness." More often than not, adolescent and adult "problems" have their roots in childhood ego development difficulties. A compelling point is made by Joseph Kaufer in a poem: lack of love, the principal energy of the universe, causes one young person to be hospitalized:

> I am in a straightjacket---you think that frightful?
> What do you think I was in
> Before I came here?
>
> I, a Depressed Case, could only see sadness.
> The doctor urges me to see that there is happiness
> in life,
> Miserable as he is.
>
> The Elderly Patient
> Hurry, Death, Come visit me.
> Do not wait for Visiting Day.
> My children will not visit me;
> I know you will---Do not delay.
>
> I loved my parents,
> Then I loved the boy across the street, not wisely,
> Then I loved a man in my office, married,
> Then I loved two others, unmarried,
> Then I loved my doctor, and my analyst
> And I am trying now to love the attendants.

I wish someone would love me.[1]

What irony! The community, out of "loving concern" condemns this person to seek wholeness and worth amont the insane when it was not possible to find it among the "sane". Depression causes more suffering and hospitalization than any other single disease, whether psychic or physical. It is a reality. It cannot be legislated away or semantically manipulated away. It must be dealt with.

Suicide Attempts

Suicide is usually the result of helpless hopelessness. It follows, generally, from an advanced stage of depression when the first and second lines of coping mechanisms don't work. There is no need to quibble over whether the person is mentally ill in anybody's definition. The question is whether the person is in a condition to assess properly whether he really wants to make a truly irretrievable decision to end life. The law of the land stands unequivocally against allowing such an action to go undeterred. The moral conviction of people moves in the same direction and is the source of the enactment of the law. The opportunity for suicide is present to everyone. History is replete with instances of persons in full command of their faculties choosing the suicideal act as more meaningful and noble than continued life.

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[1]Joseph Kaufer, "In a Straight Jacket", in From the Insane Asylum, (Waukeegan, Illinois: McAllister Books, 1966).

of suicide to healthy coping with life's challenges, and with gratitude for the chance.

This writer has counseled many clients who have attempted suicide two, three, and four times. Their presence in therapy attests to their being unsuccessful. And many of forays to the edge of life were kept from becoming one-way trips by concerned others. These clients went through therapy and re-established living and growing links with their families and jobs.

Because of the weight of numbers, the CMHC provides a high proportion of short-term therapies to its clients. The luxury of psychoanalysis, a notoriously long-term treatment process, is denied those few staff members trained to do it, Even with short-term treatment, therapists invariably find, behind the presenting problem or complaint and its symptoms, ego or personality deficiencies that are traceable to childhood. Many people never had a chance to prepare for adult decision-making, for sorting things out, for standing straight amidst life's school of hard knocks. Many of these will voluntarily seek out the friend, the counselor, the therapist who will help them help themselves. But some few will be so shattered by life's experiences that a friend from the community (clerk of court, law enforcement officer, psychiatrist, judge, or family) must intervene to protect from danger and offer the means to build ego strength and self-control that poses no threat to others.

In "Suicide: The Gamble with Death", Gene and David

Lester make some pertinent comments:

> Most suicidal people are undecided about living or dying, and they "gamble with death" leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling. Often the cry for help is given in code. These distress signals can be used to save lives.[2]
>
> Fortunately, individuals who work to kill themselves are "suicidal" only for a limited time. If they are saved from self-destruction they can go on to live useful lives.[3]

E. S. Schneidman, this country's ranking thanatologist, has distinguished the following types of suicide:

> Four types of suicidal crises are: 1) impulsive suicidal behavior following anger, disappointment, or frustration; 2) the feeling that life may no longer be worth living (feelings which one doesn't realize will eventually go away); 3) very serious illness; 4) "communication" suicides may occur when one wants to change the way another acts.[4]

The analytic studies of these authors (see also, Suicide and Mass Suicide by Joost A. M. Meerlo) give good reason for the valid concern of people in general about seeking hospitalization or other appropriate treatment for friends or neighbors who are seen as a danger to themselves.

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[2]Gene Lester and David Lester, Suicide: The Gamble with Death (Prentice-Hall Inc., Englewood Cliffs, N. J., 1971). p. 3.

[3]Ibid. p. 4.

[4]E. S. Schneidman, Some Facts About Suicide: Cause and Prevention, (U. S. Government Printing Office, Washington, D.C., 1965). p. 5.

The commitment process that deprives a person of liberty is seen as necessary to carry him through his suicidal crisis.

What we call mental illness is simply a catch-all term for a person's inability to effectively cope with the problems of life from inner-directed motivation. Acute and chronic psychotic and neurotic conditions, situational disturbances that result in emotional and mental disorganization are affecting, in a significant way, upwards to 35% of the population.[5] A relatively small percentage of that 35% is ever committed to mental health treatment facilities. Forsyth County, population 228,000, has an average of ten commitment cases heard each week, four of which are determined by the judge to need in- or outpatient care. The State steps in to ensure that threatening danger is inhibited and that appropriate treatment is provided.

Szasz' "myth of mental illness" stance misses the point. Perhaps the larger question of who is sane and who is insane has to be faced. The sanity of the sane often, very often, leads to decisions that can only be termed irrational, self-destructive, and absurd. Examples abound in our everyday "sane" world: destroying a nation in order to save it (vietnam); fattening cattle on hormone injections that are carcinogenic; incarcerating people for sexual and violent acts which they are stimulated to perform by our mass media's influ-

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[5] You Have a Right to Know, Pamphlet published by the Mental Health Association of Forsyth County, North Carolina (1975).

ence; etc., etc.

In the film, King of Hearts, we have a vivid dramatization of man's dilemma about whether he lives in a sane or insane world:

> As World War I nears its end, a battalion of retreating Germans arranges for an entire French village to be blown up by placing a booby trap in the town square. The trap is triggered to explode when an armored knight on the church clock strikes the hour of midnight with his mace. As the villagers evacuate their town, one of them gets word of the bomb threat to a nearby Scottish regiment although he is unable to give any details. Consequently, a mild-mannered private named Charles Plumpick is sent to investigate. By the time he arrives at the village, he discovers that the only inhabitants are the inmates of the local insane asylum. A harmless and carefree lot, they crown Plumpick their King of Hearts, move into the homes and shops of the town, and assume the various roles of barber, bishop, duke and duchess, bordello proprietess, etc. Ignoring Plumpick's frantic but futile search for the bomb, they devote their energies to preparing for a royal wedding between their newly-crowned king and the girl they have selected to be his queen.
>
> Eventually a chance remark by the queen leads Plumpick to the village clock and he discovers the bomb's detonator a few minutes before midnight. As Plumpick's regiment marches into the town they come face to face with the German battalion that has returned to see why the booby trap failed to explode. Both sides open fire and every last man is killed. Witnessing the senseless slaughter, the inmates voluntarily elect to return to the relative sanity of the asylum. Although Plumpick is assigned to another unit, he does not remain with it for more than a few minutes. Discarding his uniform and equipment, he returns to the asylum, stands completely naked before a pair of startled nuns, and waits to be committed.[6]

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[6]Phillippe DeBroca, King of Hearts, (Lopert Films, 1966).

Ronald D. Laing, a psychiatrist of a more radical mold than Thomas Szasz, can very well identify with Plumpick and his newfound friends. Laing advocates non-intervention in a schizophrenic's delusions; it (the non-intervention) springs from his insistence that all human experience is potentially valid and potentially intelligible, that none of it should be discarded into a garbage heap for incineration by mental health sanitary engineers.

In The Politics of Experience, Laing describes a bomber formation that is off course with one of its own planes off course from the formation itself. He concludes the description with this comment:

> The perfectly adjusted bomber pilot may be a greater threat to species survival than the hospitalized schizophrenic deluded that the Bomb is inside him. Our society may itself have become biologically dysfunctional, and some forms of schizophrenic alienation from the alienation of society may have a sociological function that we have not recognized...[7]

Even in an insane world, people have a right to be protected from unreasonable, unjust, and unlawful harm. This basic right to survive, albeit in a world that is hypocritical and irrational, must exist and be protected.

One has but to read Sydney Lens' "Doomsday Strategy" in the Progressive magazine[8] to appreciate Laing's position about the deluded schizophrenic. Lens' article, say the editors, is the most important they have ever printed. It shows

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[7]Ronald D. Laing, The Politics of Experience, (Ballantine: Pantheon, 1967), p. 147.

[8]Sydney Lens, "Doomsday Strategy" (The Progressive, Madison, Wisc. February 1967) Vol. 72, Number 2, p. 91.

how present American and world policy toward nuclear capability for war and industrial uses is leading us inexorably toward Armageddon, the final conflagration. It makes clear that Laing's seemingly absurd radical statement, quoted above, is not really so absurd. It is quite possible that deluded schizophrenics might divert us from the "bomber formation" course we are now on, under the leadership of elected officials and their department heads.

The construction of a bomb that can destroy the would-be users has shocked man into at least seeing the insanity of allowing technological progress to outpace man's wisdom and restraint. Likewise, the ecological sensitivity of modern man, prompted by ubiquitous pollution and the energy crisis, has been awakened to the insanity of recklessly exploiting the earth. The film, Catch-22[9] caught this theme in tragicomic form. There was only one catch and that was Catch-22, which specified that a concern for one's own safety in the face of immediate and real dangers was the process of a rational mind. One of the men of the bomber squadron is obviously crazy. He could be grounded if the doctor diagnosed him as such. All he had to do was ask; and as soon as he did, he would no longer be considered crazy and would have to fly more missions. The man would be crazy to fly more missions and sane if he didn't, but if he didn't want to he was sane and had to. The anti-hero of the film, Yosarian, was moved very deeply by the ab-

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[9]Joseph Heller, Catch-22, (New York: Dell Publishing Co., 1970), p. 87.

solute simplicity of this Catch-22 reasoning and it caused him to let out a very respectful whistle.

Robert Lifton quotes a Japanese scholar as saying before he died of bomb effects at Hiroshima: "The Americans are a great people because anyone who makes such a terrible weapon must have greatness in them."[10]

Perhaps, man's development as the spearhead of evolution on earth has had to go through a stage (millions of years?) of living on the brink of a Catch-22 existence. Perhaps every age could look at itself and see its closeness to mass insanity, the result of making the wrong decisions in the face of dilemmas too complex or demanding for easy and mutually beneficial resolutions.

So Szasz maintains that mental illness is a myth; Laing, that schizophrenia (severe form of mental illness) could be an advanced and insightful form of judging human experience; Heller and Lens, that the rationality of the sane is accelerating the world toward its self-destruction. This leaves us in an unenviable position of not knowing whether we are like dinosaurs that will become extinct or like the sharks which have managed to survive as a species for millions of years. In the meantime, we must live in the world we are in regardless of how it is interpreted, analyzed, and judged. One of the supreme values still motivating people is that their own lives and the lives of their own countrymen, if not of the rest of manking, should be preserved. It is in this basic context that

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[10]Robert J. Lifton, The Survivors of Hiroshima, (New York: Random House, 1968), p. 172.

commitment laws make sense. Society has opted for laws, as enshrined in various forms in the different states, that protect the many from the few and the few from themselves.

The citizenry is saying, through its elected lawmakers, that laws are needed, at this stage of our societal development. These laws enable a recognized legal authority to decide that a person, who may have broken no law, should be "treated." This treatment is aimed, simply, at enabling the individual once again to be in a position to control his actions responsibly for his own good and without threatening the rights of others.

CHAPTER III

COMMITMENT AS SZASZ SEES IT

This chapter is a distillation of the criticism of our American commitment philosophy and procedure as Dr. Thomas Szasz presents it in Chapter 4 of Law, Liberty, and Psychiatry.

Types of Commitment

According to Szasz, commitment is big business. More than 250,000 patients are committed to mental institutions each year. More than a million patients may be detained and/or treated in these institutions at any one time. By far tha majority of patients gain entrance to public mental hospitals via the compulsory or commitment route as compared to the voluntary way.

Szasz makes these dinstinctions: First, commitments are either voluntary or involuntary. The former is a decision, not coerced by judicial action, to seek treatment for a mental/emotional disorder or difficulty from a public mental health resource. This resource may be a state hospital or a local agency, e.g., Department of Social Services or a CMHC. The latter is a judicial act, empowered by the state legislature; secured, ensured, and carried out by law enforcement; and supported by the psychiatric profession's evaluation, diag-

nosis, treatment, detention, and management, against the will of the individual respondent.

Secondly, commitment can be emergency or compulsory commitment for observation for a period of up to ninety days; or, it can be regular or indefinite commitment, which entails an unspecified time.

Finally, commitment may be civil or criminal. Civil commitment involves persons who have broken no law but who are dangerous to self or others; criminal commitment applies to persons charged with crimes who are awaiting trial, and to defendants acquitted by reason of insanity.

Szasz says:

> Truly voluntary hospitalization is virtually non-existent in public mental institutions in the United States. In some jurisdictions patients may be admitted on a "voluntary" commitment," which means that they enter the hospital voluntarily rather than because of legal coercion. However, such persons are not free to leave the hospital, and their commitment is readily converted into an "involuntary" type...
>
> . . . . . .
>
> The committed patient suffers a serious loss of civil rights. In many jurisdictions he is automatically considered legally incompetent: he cannot vote, make valid contracts, marry, divorce, and so forth. In others, incompetency is a separate matter. In either case, the committed person is incarcerated against his will, must suffer invasions of his person and body, cannot communicate freely with the outside world, usually loses his license to operate a motor vehicle, and suffers many other indignities as well.
>
> . . . . . .
>
> Since commitment is a significant social fact in the life of the hospitalized psychiatric patient, one would expect that, for this reason alone, it would be of great interest to psychiatrists....[1]

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[1]Thomas Szasz, M.D., Law, Liberty, and Psychiatry, An Inquiry into the Social Uses of Mental Health Practices, (New York: The MacMillan Company, 1963), pp. 40-41.

Psychiatric Positions

Szasz then procedes to illustrate that there is little regard among psychiatrists for the problem of commitment. For example, the Fourth Edition of Modern Clinical Psychiatry[2] makes no mention of commitment proceedings or of involuntary hospitalization. This has been a standard American textbook, and Noyes was for several decades the superintendent of a state hospital! Masserman, in The Practice of Dynamic Psychiatry,[3] also completely omits the subject. Psychiatrists may be interested in the mental state of their patients, contends Szasz, but not in the legal process by which they became their patients. This is not wholesome, and prevents effectiveness in treatment by not considering the whole man and his whole history.

Psychiatrists claim, as do Noyes and Kolb in the Fifth Edition of Modern Clinical Psychiatry, that, unlike the lawyer, "The psychiatrist urges that the dignity of the patient be respected and that the obstacles to his admission be no greater than those experienced by the physically ill."[4] Szasz asserts that this is patent nonsense and propagandistic. "The history of Anglo-American law is one of unremitting striving for liberty and dignity in human affairs.

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[2]Ibid. p. 42. Citing A. P. Noyes, Modern Clinical Psychiatry, Fourth Edition, (Philadelphia: Saunders, 1953).

[3]Ibid. p. 41, Citing J. Masserman, The Practice of Dynamic Psychiatry. (Philadelphis: Saunders, 1955).

[4]Ibid. p. 41. Citing A. P. Noyes and L. C. Kolb, Modern Clinical Psychiatry. (Phiadelphia: Saunders, 1955).

Can organized psychiatry match this proud legal history? Hardly."[5]

Psychiatry as an organized profession has certainly not received the pressure from the public to reform itself in the direction of human liberty as has the law. Some of the reasons for this are obvious, e.g., psychiatry is a very esoteric thing; it does not impinge on the masses as does the law; it is less vulnerable to attack; psychiatrists work in the background when their services are required by judges or attorneys(though they were quite prominent in the Patty Hearst trial of 1976).

I do not believe the history of Anglo-American law deserves the encomium that Szasz lays upon it. American Indians, blacks, women and the poor would certainly not plaudit its "unremitting strivings." Tired of blood, sweat and tears, these groups have had to amass themselves into campaigns and crusades to force the history of Anglo-American law to move in the direction of liberty and dignity.

Nevertheless, the point is well taken that psychiatrists are not renowned for their efforts to increase the chances for liberty of those who are in danger of commitment nor of changing the conditions in state facilities that would enlarge and ensure the use of their civil rights.

Szasz points out how Linn, in his book on hospital psy-

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[5]Ibid. p. 42.

chiatry, justifies the loss of rights a hospital patient incurs upon admission. This interpretation of a court decision is important, and will be quoted in full:

> These rights are taken from them in the words of the Iowa Supreme Court "to aid and assist the individual, to provide means whereby the state may protect its unfortunate citizens, to furnish hospitalization so that the insane will have an opportunity for rehabilitation and readjustment into useful and happy citizens. It is not a criminal proceeding in any way. The restraint placed upon them is only until they have recovered so that they may again take their places in the communities from which they came. The confinement is not intended as a punishment but solely and only to provide the mentally sick with that environment which may possibly cure the disease and return them to society as useful citizens." One might wish to add that we also take into consideration the dangers to society which sometimes ensue from the actions of the mentally sick, although admittedly the importance of this factor has often been exaggerated, and it may certainly be given second place in our thoughts.[6]

What Linn failed to do, according to Szasz, was to detect the pious and paternalistic attitude expressed in the text. The assertion that commitment is not intended as a punishment betrays the actual function it serves.

The real point of Linn's position, says Szasz, is that the psychiatrist is here justifying the demands of the holders of power to make the powerless conform on the grounds of serving their best interests. This was the attitude of the slaveholder toward the slaves, of the evangelist toward the

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[6]Ibid. p. 42. Citing L. Linn, A Handbook of Hospital Psychiatry: A Practical Guide to Therapy. (New York: International Universities Press, 1955).

heathen, of the colonialists toward the natives. Linn, says Szasz, strives mightily to reconcile the needs of the individual and of society, but fails in the attempt. Linn is admitting to the necessity of social control of the citizenry by the psychiatrist, while Szasz holds that such a role belongs elsewhere.

George Orwell, in 1949, wrote of "newspeak" in 1984.[7] Newspeak is the final form of control that a totalitarian government has of achieving complete management of the mind of each member of society. Old words are given new meaning, usually the opposite of the original. It is a technique of brain-washing that is employed by politicians, authority figures, and, even, lovers. Szasz asserts that psychiatrists also resort to rhetorical manipulation in an effort to relieve their guilt as they play their dubious roles as social engineers and people-manipulators. He cites a proposal by the Group for Advancement of Psychiatry:

> The Committee believes that all statutes should delete the term "commitment" in place of which should be substituted the term, "certification"; "insanity" and "lunacy" should be replaced by the term, "mental illness", and the terms "feeble-minded" or "weak-minded" should be abandoned. The Committee believes that the term "parole" should be abandoned and in its place the term "convalescent leave" should be substituted.[8]

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[7]Ibid. p. 43. Citing George Orwell, Nineteen Eighty Four (New York: Harcourt Brace, 1949).

[8]Ibid. p. 43. Citing Group for Advancement of Psychiatry, Commitment Procedures, Report No. 4 (Topeka, Kansas 1948).

American law, on the other hand, has, in Szasz' estimation, a laudable heritage of concern for human dignity that far outstrips that of forensic psychiatry:

> In the Law's appraisal, a blind man is not of a different species from one who has the sight of his eyes. A blind man is simply another member of the total society; he must take suitable and reasonable precautions for his and others' safety. So must a man who is too short or too heavy, or whose reflexes are slowing with the years; so also must every one of us.---Persons who are afflicted and disabled must not be categorized even by themselves as an inferior or pitiable species. They are, on the contrary, men in all essentials like their neighbors---with the needs, duties, dignities, and singular potentialities of the genus.[9]

Szasz says a good contrast can be found between two poles of view held by psychiatrists, the preponderant number being on the negative, coercive and medical model side. There is, for example, the view in Henderson and Gillespies's textbook:

> Apart from the medical side, the social and economical circumstances are often deciding factors for and against certification. Certification is desirable where no adequate accomodation at home or in a special nursing home is available or where money is a consideration. Certification is unnecessary where adequate arrangements for treatment can be made outside of mental hospitals, and undesirable where the patient occupies an important public position, e.g., director of a company, partnership, etc.[10]

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[9]Ibid. p. 44. Citing E. Cahn, The Moral Decision: Right and Wrong in the Light of American Law (Bloomington, Indians, Indiana University Press, 1956).

[10]Ibid. p. 44. Citing I. Belknop, Human Problems of a State Mental Hospital (New York: McGraw Hill, 1956) pp. 220-221.

This can be compared to Davidson's view:

> Hospitalization proceedings should involve a maximum reliance on medical judgement. The basic question in deciding whether a person should be hospitalized is his health and his medical needs. The model law follows the current trend of placing major emphasis in any admission procedure on the conclusions of qualified physicians who have examined the patient.[11]

This writer feels a large question has to be raised at this point: does commitment to a mental institution really serve the psychotherapeutic needs of the individual committed, or the peace, convenience and social philosophy of the community? Regardless of the personal philosophy of the psychiatrist, he must deal with the implications of both parts of the question if he is to function successfully in the public agency. Thus, a psychiatrist who commits a patient to a mental hospital is acting as an agent of the community as well as to the individual's personal needs for well-being.

There is no question that a person can receive beneficial therapy at a mental institution if the goal is to conform that patient to society's demands or norms. Szasz' question is, can therapy be given that meets the individual's needs for autonomy and self-control. Szasz holds that the commitment process does not lent itself to this kind of self-development.

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[11] Ibid. p. 44. Citing H. A. Davidson, Forensic Psychiatry (New York: Ronald Press, 1952) p. 181.

Justification for Commitment

In state statutes, the justifications for commitment include one or more of the following: 1) the person is psychotic; 2) he is dangerous to himself; 3) he is dangerous to others; 4) he is mentally sick but does not seek treatment.

Szasz thinks these reasons are quite arbitrary. Most psychotics are not committed. Elderly persons, offenders and addicts are committed, but not usually considered psychotic. The danger to self or others is totally undefined. Certainly, heavily drinking drivers are a serious danger, yet are not committed. Some people are allowed to be dangerous to others with impunity. It is not whether a person is dangerous, but just how he is dangerous.

People labelled paranoid are readily commitable, Szasz says, yet they kill a disproportionatley few people compared to the drunken driver. "Some kinds of dangerous behavior are even rewarded. Race-car drivers, trapeze artists, and astronauts receive admiration and applause. In contrast, the polysurgical addict and the would-be suicide receive nothing but contempt and aggression. The latter type is considered good cause for commitment."[12] Szasz is thus showing the double standards and inconsistency of the law that discriminates against the mentally ill.

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[12]Ibid. p. 46.

Commitment as a Social Restraint

From a psychosociological point of view, many more inconsistencies surface. The issue of social disturbance is foremost among the social or community factors. Social disturbances are caused by old people who cannot care for themselves; by one who threatens to kill himself or herself; by someone who claims a belief that threatens society, a belief which is the result of his delusional system or hallucinations; and by those who seek sexual gratification in bizarre ways.

There are similarities between the offenses of the mentally ill and the criminal. Both "offend" society and thus are restrained. The motives for this are different, one being therapeutic, the other, punitive. Incarceration, Szasz says, in a mental institution, is often the more severe form of punishment.

This writer feels Szasz is justified in this comparison of the two forms of incarceration. There were present in mental institutions conditions that even prison inmates were spared. A mental hospital resident was on an indeterminate sentence, which, in itself, is an unbearable burden; but he was also aware of the ultimate indignity to his humanity: that he would never be taken seriously. He could not become an advocate for his own release. He had to live in an environment of madness that conditioned his thinking, communicating, and acting that caused him to recede ever further from the world outside. He would sink ever deeper

into the mire that originally entrapped him. (See also "The Total Institution" in the sub-section below).

Szasz then brings in another ugly problem: who annoys whom? The rich and influential are rarely the victims of commitment; the poor and powerless are.

In theory, Anglo-American law has the enviable tradition of seeking fairness or justice toward every citizen without distinction of persons. But this fairness, says Szasz, does not enter the commitment game.

This is true enough; few non-poor are ever petitioned for commitment. But this is less a criticism of the commitment laws per se than of the very structure of our whole society. The well-to-do, more often, have alternative means to deal with mental illness, inebriation, and dangerousness. Friends, clergy, private therapy, psychiatric facilities and retreats, etc., can be called into play to resolve emergencies, rather than the clerk of court and the sheriff. The assistant clerk of court in Forsyth County states that, in his estimation, only three or four percent of those petitioning for commitment come from income levels above the poverty categories.

Szasz insists that when the law introduces the psychiatric profession into the legal process, discrimination also enters the picture. It is the main contention of this paper that it is the law and the general contention of the people that are dominant in court-related mental health matters, not the psychiatric profession. The psychiatrists'

limitations and biases are not causing the commitment process in our time to be unfair and prejudiced.

The psychiatrist enters the picture upon order of court. He fulfills his role as a medically-oriented person diagnosing a person with regard to that person's mental/emotional condition and its relation to "dangerousness". It is those who petition and commit (citizens and judges) who are the decision-makers in the use of the law.

The Total Institution

Mental hospitals, by their very nature, are "total" institutions. (Goffman 1957). Goffman lists characteristics of total institutions, which are quoted by Szasz: 1) all aspects of life are conducted in the same space under a single authority; 2) no room for private activity; 3) a strict daily activity schedule imposed from above; 4) the enforced activities are parts of a single overall rational plan designed to fulfill the aims of the institution.

Commitment, as Szasz sees it, condemns a person to a total control system. An atmosphere pervades such a place which quickly inures a resident from thinking and planning for himself. Conformity to the mind and will of others is quickly engendered in the patient as the way to health and final release. "Total" applies, finally, to discharge timing, which

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[13]Ibid. p. 54. Citing E. Goffman, On the Characteristics of Total Institutions in Asylums: On the Social Situation of Mental Patients and Other Inmates (Garden City: Doubleday, 1961).

is indeterminate and depends upon the judgement and will of the staff.

The Role of Deceit

The names of these institutions have changed, but they have never been called prisons, which Szasz says best describes what they are, for the majority of their residents. They were once called asylums, places of refuge; then, hospitals, places for healing. The name disguised what was taking place behind the facade. In Szasz' opinion, there is more honesty in a prison, where inmates and staff are clear on why the institution exists, what the goals are, and why the inmate is incarcerated.

A lady, Mrs. Packard, who gained release from a mental institution after a false commitment about which she wrote years later, quotes the superintendent of that institution on the occasion of critiquing her manuscript:

> I should like to remark here, that I don't like your calling this place a prison, so much; for it isn't so. And as I'm to superintend there manuscripts for the press, I'm not willing you should call it a prison. You may call it a place of confinement, if you choose, but not a prison. (italics in the original; page 132).[14]

Szasz maintains that commitment can be compared to

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[14] Ibid. p. 55. Citing E. P. W. Packard, Modern Persecution, or Married Women's Liabilities, As Demonstrated by the Action of the Illinois Legislature. Vol. II. Published by the Author. Hartford: Case, Lockwood, and Brainard, Printers and Binders.

slavery: both the slave and the mental patient are disenfranchised and forced into a servitude, euphemistically called, for the patient, "treatment". There is a strict master-slave relationship glaringly apparent in the "hospital". Patients are treated as if they didn't know how to be anything except patients. Like slavery, commitment serves the public interest. The "public good" requires their isolation, incarceration, and servitude. Carrying the comparison further, Szasz points out the violence in mental hospitlas, The violence is not only physical and psychological, it is "medical"; it is done in the guise of "treatment". Lobotomy, convulsions induced by insulin and electroshock therapy, and most recently, the chemical straightjackets.

The patients are rarely helped, says Szasz. These great warehouses were never meant to help, anyway. Their main contribution to their charges is to teach them to accept their subservient, oppressed status in an uncomplaining manner.

Szasz concludes that the whole system of involuntary commitment simply has to be abolished; it is irredeemable. He sees no way in which involuntary commitment can serve the individual or society. The basis for this despair of the system is his deeply-rooted conviction that law and psychiatry cannot mix; that mental illness is a myth that is kept only because it eliminates human problems that cannot be solved as easily in other ways; and that we are not fully committed to due process of law for all citizens. It is this writer's thesis that we need not despair of the system, but that wholesale improvement is feasible and in process.

CHAPTER IV

NORTH CAROLINA: COMMITMENT TO COMMITMENT

Dr. Thomas Szasz wants to eliminate all involuntary commitment procedures from the fifty states. We have reviewed his reasons. This chapter is not a point-by-point refutation of Szasz' theory; rather, it is an evaluation of the "commitment situation" in North Carolina, as seen from a middle point, the Community Mental Health Center, standing between the community and the state institutions.

The Case of Mr. Ness

A physician at a large state hospital told a social worker at the community mental health center that the best place for Mr. M. D. Ness was "in a cemetery plot." Ness had been treated in the forensic unit of the state hospital for assault charges, judged to be in a state of mental and emotional dysfunction, and transferred to the ward for the mentally ill. Apparently, he was a bit disruptive and obnoxious there. A physician judged him as untreatable; i.e., no treatment regimen was calculated to benefit his condition. He was returned to "the community" that had now been "mandated" to care for him.

In "the community", he fared badly. His six-foot-four frame bore a 1920's fur coat in the summer. Landlords

of the inner city rooming shacks would no longer accept him in their "inns". Relatives and friends had disowned this 28-year-old wrecker of their domestic peace. Agency people cowered in their offices as he made his rounds accumulating magazines and pencils. The community police had braced themselves for a trying encounter when the next petition for his commitment would be signed. He had had many stints as an involuntary patient.

He made the television news one night in August 1975 after reporters and photographers surrounded him in his encampment on the lawn of the Department of Social Services in Forsyth County. He had spent the preceding day in a take-over of the DSS building, his bulky presence intimidating the workers.

A policeman signed a petition for his commitment. Once again, the state hospital received this in-again, out-again resident. A call was made to the same doctor who had tried in vain to "treat" him so many times before. The physician vowed he would not recommend keeping Ness in the hospital after the commitment from District Court. Since the General Assambly, in 1974, had decreed that the state hospital would no longer be a custodial care institution, the "community" would henceforth have to bear the burden of care for "untreatable" Ness.

This threat was a clear call to concerned agency people. They assembled, with this writer among them. We honestly sought the living arrangements Ness needed in the community as well as the assurances that people who cared

would help him manage his life without stealing, assaulting, and intimidating. We could come up with no solutions, no answers!

We called the doctor. We explained the community situation. He relented and the hearing was waived. M. D. Ness remained at the hospital. There are between 90 and 180 days for the community either to find a place for this disinherited citizen, or request will be filed that he be declared a ward of the state.

This was no kangaroo court. This was no snooty disdain of an "idiot". There was no question of the mental illness. The medical model was not narrowly at work. Social workers, nurses, police, agency administrators---all honestly sought a way to care for a brother. Commitment was a last resort.

Were we falling prey to the myths and faults that Thomas Szasz discusses in forensic psychiatry? All the questions came into play in this case: Are men ruling or is the law the rule for decisions about a man's guilt and punishment and commitability? Is this man s behavior the product of mental illness, or is he simply living up the the label he has been tagged with ever since his adolescent years? Is society guilty of such neglect and maltreatment that his condition is a direct result, or is he organically pathological? Were the evaluating and treating psychiatrists manipulating the person, engineering the society, and making a decision based on cultural bias? Were the non-medical pro-

fessionals victims of their awe of the psychiatrist when they confirmed the medical decision? Were we so culturally biased that we could not fathom how such deviant behavior could possibly be "managed" in the community?

Mr. Ness returned to Winston-Salem after five months at the forensic unit in Dorothea Dix Hospital. He had been "stabilized", i.e., in a structured environment, he had gotten habituated to regular medication and the assurance that he could trust others to help him meet his needs. The Department of Social Services found him an apartment. Right now, he's doing fine; he and the community are compatible.

What Thomas Szasz wrote in 1961 about commitment, he is still saying on the lecture circuit and in magazines. As we evaluate his positions, let the reader be cautioned that there are no definitive, objective true-false positions.

There is an impelling need for the law enforcement system, especially the courts, and the citizens, to take quick action to protect themselves or a disturbed person when dangerous behavior occurs. True, the policy and procedure for commitment can be abused. But nothing exists that cannot be abused. The question is: in 1976, does the need for court-initiated commitment exist?

Further Examples

Let us consider some examples. The first four are

taken from an article by Carole Offer in Psychology Today:[1]

A woman insisted on leaving a mental hospital against medical advice. She had not been eating, but she was not overtly psychotic. Three weeks later she died of malnutrition.

A husband tried unsuccessfully to commit his wife. Shortly thereafter, she beheaded her infand son and daughter.

A released patient, after a short treatment, murdered his wife and three children before killing himself.

A policeman failed to have two female adults committed when he found them standing on a corner staring into space. Later that day, other officers were called into an apartment, where they discovered the two of them heaped on the kitchen floor "smouldering in the middle of a suicide pyre."

The following disguised cases are drawn from the files of a community mental health center:

Mrs. X roams the streets at night in the nude. John Doe inflicts wounds on his wife with abelt when upset by minor provocations. Ms. Jones hallucinates frequently and as a direct consequence denies she is the wife of her husband and denies him bed and board, asserting he is only a renter. Young Hank, married for a few years, the father of an infant son, smothers the boy with heavy blankets to drown out his

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[1]Carole Offer, "Civil Rights and the Mentally Ill: Revolution in Bedlam" (Psychology Today, October 1974. Vol. 8, No. 5. pp. 60-61.

night cries. Frank, a retired railroad conductor, shoots a rifle at motorists passing in the night. Sudie Smith, mother of three young children, wife of a truck driver, suffers blackouts from excessive drinking. Alone, fearful, and without food, the children are developing a routine of staying with a neighbor, remaining away from school, and showing the effects of the strain in hostile behavior.

Petitions for commitment were signed for each of these persons by spouses, neighbors, or the police. They were either adjudged mentally ill or inebriate, and at the same time, dangerous to self or others. They received either inpatient or outpatient treatment. In all cases, efforts were made to involve the family members in the treatment process, with special emphasis on post-discharge planning.

Patients' rights is a hot issue. It boils on the burner and its steam has caught the attention of the citizenry and the legislators.

Articles 3 of General Statutes 122-55.1 and 122-55.2 are devoted to this matter; they were passed and codified into law in 1974. See Appendix H. There is no loss of civil rights on the basis of being a committed mentally ill or inebriate person. (One exception concerns the license to operate a motor vehicle. This is treated in Chapter 20 of the General Statutes, and has its own pertinent reasons and justifications).

The Mental Health Association

The Mental Health Association chapters in the various communities of North Carolina have been ardent advocates for the rights of the mentally ill. As lobbyists, proposal-makers, articulators of the mind and will of the mentally ill, they have influenced legislation in the direction of these patients' freedom and dignity. In addition, they conduct periodic surveys of patients' feelings about the treatment they received in mental health facilities.

During 1975, Association members visited mental health institutions throughout the state, in company with North Carolina State Department officials from the highest levels. Their visits were precisely to ascertain the kind of therapeutic treatment offered, and the opportunity for the exercise of patients' rights. The results have not yet been published, but the Executive Director of the Forsyth County chapter said members have come away generally impressed with the progress being made and the compliance with the laws on commitment procedures and the exercise of rights. The rights of citizens forcibly or freely detained and treated in psychiatric hospitals or at community mental health centers, they felt, are no longer grossly denied or abrogated. Their study will include recommendations to improve both the commitment laws and the living conditions at the state facilities.

In the Spring of 1975, the State Department of Human Resources initiated a follow-up survey of 140 former patients

at psychiatric institutions and community mental health centers. This report has also not been published, but one of the surveyors, now on staff at the mental health center, commented as follows on the attitude of a preponderant majority of patients toward their stay at John Umstead Hospital. First, the patients highly praised the ward nurses and aides for their attitudes and for care given. Secondly, the patients said their stay had been beneficial to them therapeutically, i. e., it was a significant or major factor contributing to their return to the community. Thirdly, they asserted, understandably, that they did not want to return. Fourthly, there were few complaints about the physical conditions of food, privacy, cleanliness, recreation, etc. Fifthly, many complaints were registered about the excessive freedom allowed fellow patients to violate their own privacy of person or possessions. Lastly, many former patients expressed regret that they did not see the professional staff for treatment as often as thepatient felt was necessary.

Voluntary Commitment

North Carolina, among an increasing number of states, has defused Thomas Szasz' statement that there is no such thing as truly voluntary hospitalization in this country. General Statute 122-56 clearly grants to any citizen the right of voluntarily entering a mental health facility.[2]

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[2] Appendix I.

The only qualification to this guarantee is that the "illness" be of a psychiatric nature, that it be treatable and that local mental health resources are inadequate for proper treatment.

Shortly after the enactment and promulgation of this law, the state hospitals found patients leaving the hospital within hours of being admitted; other patients, within days. So large did this abuse become that the 1974 Legislature had to amend the act to state that once a person was admitted to the hospital after screening and evaluation, which had to be done within 24 hours, he could not be released before 72 hours had passed. He or she was then free to depart even against medical advice.

The too-easy permission for leaving the hospital overtaxed the clerical and clinical staffs. Needless paperwork and clinical effort were being expended.

Furthermore, patients easily experience an overreaction to their initial anxiety after entering the new hospital environment. They are more readily inclined to leave than to settle down and give themselves time to test and evaluate their treatment. Early departure can often only increase their anxiety, weaken their self-confidence, and aggravate the very problem that brought them to the hospital.

The Right To Freedom From Care

Szasz devotes Chapter 15 to the hospitalized mental

patient's fight for freedom. He states[3] that patients seeking release are denied their requests and that patients are not even listened to because they are psychotic or insane and are, thus, incapable of defining their own self-interests.

North Carolina has made this objection obsolete. Voluntary patients can get released within 72 hours. Involuntary patients must receive a hearing after 90 days before the judge of the district where the hospital is. At this hearing, they can either be released or further committed for 180 days. If committed, there is yet another hearing at the end of the 180 days, in which the entire matter of their stay is reconsidered. Again, they must be adjudged imminently dangerous to self or others in order to be detained---or they must be released. There is full provision for an adversary proceeding, with the right of defense counsel, privately retained or provided by the state.

The Money Problem

Another factor is at work for the benefit of the committed patient: Fewer funds, proportionately, are being allocated to the state hospitals as more is being poured into the community resources. There is now a clearly observable tendency for the state institutions to limit severely the patient population. The clerks of court and the judges have

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[3]Thomas Szasz, M.D., Law, Liberty, and Psychiatry An Inquiry into the Social Uses of Mental Health Practices, (New York: The MacMillan Company, 1963). p. 169

gotten the message. Petitions for commitment are now more closely screened, and assignment to outpatient commitment is more often being chosen rather than send patients to the state facility

People complain to mental health staff clinicians that the clerk of court or the magistrates are unwilling to accept petitions for commitment. This is forcing the community to work extra hard to find solutions that were formerly taken care of in the "easy" way of judicial commitment. More and more, it is the patient's family, the neighbors, or the local CMHC staff who are now being called upon to "live" with the person.

The Forsyth County Assistant Clerk of Court in charge of commitment, stated to me that his records for 1975 show about 420 commitments were decided by the district judges. About 75 of these were for alcohol abuse with another 35 showing an accompanying psychiatric diagnosis. This is a reduction of some 230 over previous years, due to the 1974 legislation that prohibits jailing alcoholics.

The overall number of commitments has not decreased much, in spite of the reduction of alcoholic commitments, because of the growth in population, the 1974-75 recession and the increasing knowledge people have about commitment processes.

The clerk of court further states that the number of petitions for commitment has increased significantly, but more of them than formerly are being rejected by him and by

magistrates or dismissed by the judges.

It is now more difficult to retain patients in a state facility, just as it is more difficult to obtain a aommitment . There is a broader, more definable, and individually applicable treatment modality available for the patient seeking help. The local community resources are now much better integrated and synchronized with the state resources. There is less chance that a person will be walled away from his home and community against his will, or without the concern of someone in the home community, be it family, friends, or agency personnel.

The World Around the Patient

Szasz laments the poverty of concern for the dignity, freedom, andpersonhood of the patient by the psychiatrist as compared to the lawyer, and the psychiatric misuse of words to manipulate patients and the law itself. Further, he sees the psychiatrist as so bound by the medical model (concentration on an identifiable and locatable pathological condition) that he is blind to the social and economic factors of the patient's condition.

Two important testimonials belie thsee accusations in Forsyth County. One is the testimony of the local mental health center's forensic social workers; the other is that of numerous petitioners seeking commitment of their family members, relatives, or neighbors.

A great number of petitions are rejected out of hand

by the clerk of court, before an evaluation is ever made by the psychiatrist. Experience with the commitment petitions, knowledge of the current laws, and of the historical factors that led to their enactment; awareness of the climate that has brought the "rights" issue to prominence---all these conspire to make the clerk of court and magistrates sensitive to the issues involved. They are less likely than in previous years to accede to every petitioner's demand. It may be disturbing for a schizophrenic to be intolerably bothersome to the family, or for a man to preach each day at the passersby, but these offenses are no longer grounds for commitment. The evaluating psychiatrist knows he can no longer make a case for commitment to a judge and district attorney on the basis of his own professional status alone.

In times past, social and economic factors were overlooked in assessing the reason for a person's actions. Statistics and publicity have sharply focussed everyone's attention on the power of social and economic deprivations to influence a person's behavior. Szasz says that psychiatric professionals do not take this into account as they declare a person fit for psychiatric treatment, and therefore, commitment. Judicial personnel and psychiatrists know as well or better than anyone when the social and exonomic are a part of the cause of a person's dysfunction, as well as a part of its resolution.

There were the days when prosperity appeared to reign; when the "colored" peoples of America were still un-

seen; when the "War on Poverty" had not yet been conceived. Psychiatrists could, perhaps, be excused an insensitive attitude before 1960. No allowance for this attitude could prevail today, nor, indeed, is it found among any of the evaluating psychiatrists this writer has encountered. Psychiatrists, as well as other mental health professionals are aware of the entangling interplay betwen one's body and psyche, and the surrounding cultural forces.

The Individual and Society

There is another aspect of the psychiatrist's position on commitment that is of crucial moment. It is the conflict between the individual patient's needs and those of society.

Szasz quotes from the book, The Mental Hospital by Schwartz and Stanton:

> But, however much or little he knew about the community, the psychiatrist either submitted to being an agent of the community or he abandoned work with the really seriously ill. He had no other choice. The community has strong and effective techniques of maintaining order; it might be stupid or enlightened, brutal or friendly, closely integrated with the hospital or distant, and occasionally it was all of these. But it protected itself. The license for the hospital to operate was granted by the town government and had to be renewed each year. There was never any serious question about its renewal, but the license dramatized the fact that, regardless of the personal values of the psychiatrist, protection of the community would take priority over the therapeutic purpose of the hospital, if there was an obvious conflict between the two. The hospital had to be suc-

cessful in this purpose, and it was.[4]

It is understandable that the psychiatrist in the early fifties would consider himself an agent of the community before being an advocate for the fullest possible freedom for the patient. It was the day of herding the insane into large institutions away from the perplexed public ashamed of the people in its midst who performed strange antics. It was the age before the discovery and successful use of a wide range of psychotropic (mind/mood altering) drugs. These drugs have calmed and compensated people, prevented severely disturbing and disorganized psychotic episodes, and given hope to patients and collaterals alike that commitment or hospitalization, voluntarily chosen, are not necessary. It was the final decade before the launching of the comprehensive community mental health system.

In North Carolina and in many other states, there is positive legislation to reduce the population of the large-scale institutions where staffs are never at a level to provide the best standard for quality care. Likewise, community mental health centers have more than a full share of the work without receiving outpatient commitments unnecessarily. The clerks of court and magistrates who sign petitions and issue orders that send the sheriff to pick up the allegedly dangerous respondent, guard their responsibility over the law

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[4] Ibid., p. 45. Citing A.H. Stanton and M.S. Schwartz, The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment. (New York: Basic Books, 1954).

jealously. They are in a very strong position to screen petitions at their origin. Whether a respondent ever gets to the psychiatrist for evaluation depends on their determination. These officials are strongly urged, by the laws presently in effect, not to admit new clients into the judicial system without compelling reason. Court dockets are crowded; the sheriff's manpower is likewise limited, forcing the clerk of court to put as few burdens on that department as possible. Not only would the sheriff or his deputies have to Pick up the respondent where he has become "a problem", but, if the person is committed to inpatient care at a state facility, they would be required to transport the patient there, and then back again for a hearing within ten days. Tnese factors conspire toward leniency in the respondent's favor and place more constraints and obligations upon the community.

The evaluating psychiatrist deals with the clerk and the sheriff and his deputies on a continuing basis. Though a minor factor, this admittedly distant interface serves to keep the psychiatrist mindful that community and patient are affected by his evaluation, both having their respective rights and duties.

Another factor enters. The CMHC has been designated by the State Legislature as the "one portal of entry" for any person into the mental health system whether treatment be given locally or at a state facility. This is beaurocracy at work! At least, it results in the psychiatrist at the CMHC knowing he is working on a standard that is monitored and further evaluated by clinical and administrative personnel at

the local and state levels. The CMHC psychiatrist is thus well-advised to act professionally and accordint to current laws and community attitudes. He is not likely to succumb to the various temptations that Szasz refers to, viz., social engineering, denial of individual rights, subjegating the law to therapy, serving the needs of the community at the expense of the individual.

The Forsyth County CMHC established in 1975 an outpatient commitment coordinating position. This staff person has the primary task of providing treatment, personally or through other designated professionals, to two categories of committed patients. The first is those committed to outpatient treatment by the judge at the preliminary hearing; the second is those patients who had been first assigned to inpatient care, and were continued on an outpatient basis.

The forensic social worker not only provides treatment, but is in consultative contact with the lawyers, judges, and clerks to aid in establishing the best judicial decisions about treatment. This person is probably most immune to the influences of legal and medical factors, keeping him or her freer to consider the individual's treatment needs and the possibilities of the community to respond.

Finally, there is explicit in the reigning law of the State of North Carolina, the mandate for judges to seek out, and for mental health professionals to carry out, the least restrictive form of treatment possible. This means that outpatient treatment would be chosen over inpatient if that would

suffice a patient's needs. Likewise, the law would point to as early a discharge as possible from an inpatient facility, either to home or to outpatient care at the local CMHC.

Szasz says: "I believe that, like slavery, the entire oppressive-coercive pattern inherent in present-day involuntary mental hospitalization is an evil which must be done away with."[5] I reply that the "Emancipation Proclamation" on mental illness has been declared in North Carolina.

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[5] Ibid., p. 56.

CHAPTER V

THE COMMUNITY EXPERIENCE

"Adequate remedies are not likely to be fashioned by those who are not hostile to evile to be remedied."[1]

Dr. Szasz asks at the beginning of Chapter 5 of Law, Liberty and Psychiatry how we should judge whether a commitment is proper or not, and whether we should accept the legal criteria or search for other ones.

By the 1830's, there were a number of state mental institutions in existence where there were either no commitment laws or they were so lax that a person could be forcibly admitted for treatment on the recommendation of any physician.

A famous case of railroading, relates Dr. Szasz, was that of Mrs. E. P. W. Packard.[2] She was committed on the request of her husband tothe Illinois State Hospital in 1860. She was released three years later, claiming she was sane and had been committed only for her husband's purpose of being rid of her. The statute under which she was committed read as follows:

> Married women and infants who, in the judgement of the medical superintendent of the state asylum at Jacksonville are evidently insame or distracted, may be entered or detained in the hospital at the request of the husband of the woman or the guardian of the

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[1] Ibid., p. 57.

[2] Ibid., p. 58.

infant, without the evidence of insanity required in other cases.[3]

Szasz takes to task the modern textbook writers, who he says, glibly condemn the likes of the above law, and flatly state that our present laws are good: "by ascribing Mrs. Packard's incarceration to bad laws, we commit the error of ethnocentrism." (p. 58) Szasz maintains that, barbarous as the Illinois law of 1851 was, ours of today are still discriminatory and harmful to patients' best interests.

The forensic social worker at the Forsyth County CMHC finds no occassion of indisputable false commitment over the past few years. The present laws governing the commitment procedure and those asserting and guarding patients' rights give precious little room for the gross injustices Szasz has been railing against. In this regard, Szasz must be commended. He, and many other like-minded persons have made their voices heard. Though Szasz is still unconvinced we have made adequate progress in the commitment field, he would have to admit patients are, at least, less harmed than formerly. Mental patients are no longer "at the mercy of their loved ones and of psychiatrists."[4] In spite of the care given by current North Carolina laws to protect the individual respondent from false commitment, they are still administered by fallible,

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[3]Ibid., p. 58

[4]Ibid., p. 59

biased clerks, judges, and psychiatrists who are neither all-knowing nor all-good.

The Problem of Impartial Evaluation

The word "danger"[5] is packed with a lot of anxiety-arousing overtones and implications. When a psychiatrist evaluates a person as "dangerous" to self, or especially, to others, he is putting up a red flag that can seal out all other considerations by a judge. Psychiatrists have no corner on the market of more accurate predictions of future violence than any others.

Daniel Oran, a young advocate lawyer, writes in Psychology Today, "As one psychiatrist puts it, their attitude is often: 'I suspect he's dangerous, and I know he's a pain in the ass. But I can't pin anything on him.'"[6] Oran explains that this over-prediction of the extend of danger flows from two tendencies ingrained in the psychiatrist's training and experience. One is the training he recieves. It teaches him that over-diagnosis is less risky than under-diagnosis. Whether the physician deals with acute appendicitis or an acute psychotic episode, it is safer to treat than not to treat, to predict more, rather than less, harm from the condition.

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[5]See Chapter 5 "Is the Patient Dangerous?"

[6]Daniel Oran, "Judges and Psychiatrists Lock Up Too Many People", Psychology Today, Vol. 7, No. 3 (August 1973). p. 22.

A second reason Oran sees for psychiatrists' over-predicting, is his double duty in performing forensic evaluations. The psychiatrist is, by legal presumption, an imparital agent of both the patient and the community. Over-prediction of illness or danger causes a patient to be hospitalized and treated; the patient loses his liberty and is inflicted with a label; but it placates the community. Under-prediction may spare the patient, but it can open the way to harm to others, and bring anger and distrust upon the physician.

Psychiatric evaluation is a heavy and confusing burden. Experience at the CMHC indicates that probably 95% of all cases screened by the clerk of court are within the easy judgement of the psychiatrist to certify or not as imminently dangerous. The other 5% taxes his judgement. False commitments can and do occur on this matter of evaluating dangerousness. And, of course, this is the whole crux of the commitment process. A person must not only be mentally ill or inebriate, but imminently dangerous. Szasz and Oran are right to question the spychiatrist's role in this. They both see, "psychiatrists cast in the roles of therapist, warden, and judge. If you give an honest professional these conflicting roles, he becomes ineffectual; if you give them to a dishonest professional, he becomes a despot."[7]

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[7]Ibid., p. 27.

False Commitment

Szasz and Oran are both concerned about preventive detention. Law protects citizens from protective detention against future possible illegal acts. Admittedly, mental patients are in a different category from "normal" individuals. Protective detention because of imminent danger is built into the commitment laws and, in fact, is their raison d'etre. Human abuse and error can easily enter the picture to disinherit the patient of his rights. But on the basis of the respondent's recent past acts, the testimony of witnesses (some of whom have suffered harm), the evaluation of what we hope are enlightened and fair psychiatrists, a patient is given the benefit of the doubt. If the patient is committed, it is the result of applying most of the best means of making a judgement. True, a person should be presumed innocent until proven otherwise. In commitment cases, the clerk's signing of the petition and the physician's certification of danger to self or others are not done in a vaccuum. Proff of present illness that may be destructively expressed has to be provided, as far as human judgement can ascertain, from past acts and diagnostic evaluation.

To apply the burden-of-proof argument to its limit in commitment cases is to emasculate the law completely. Someone has to be trusted to help the community protect itself as well as the patient.

I asked the psychiatric nurse, a worker for seven years on the Forsyth County CMHC staff, if she know of any of

her nearly one thousand patients who brought suit against the State or the Department of Mental health for false commitment or detention without cause. She knew of none. She followed their course of treatment at the state hospital and gave aftercare or post-discharge treatment to most of them. She knew them well. She did encounter occasions with many of these patients when they anxiously wanted to be released. These were times when they were confused, depressed, delusional, or were simply expressing the natural, rational desire to go home. It is a big exercise of the imagination to maintain that the false commitment accusation can be applied to these cases because they willed not to be forcibly detained. Another confirmation of the paucity of false commitment complaints is the testimony of the county's assistant clerk of court. In response to my question about legal suits in the last ten years by anyone committed to the state institution at Butner, he flatly stated there were none. He knew of one in a neighboring county and of a current class suit on "due process" (but not false commitment) in another neighboring county.

Recently, a daughter brought her 62-year-old father to the CMHC for outpatient treatment. He had just been returned from a South Carolina mental hospital where he had been committed for driving in the opposite lane of a major highway, over 200 miles from home with no destination.

The psychiatric nurse saw the signals that called for immediate hospitalization. A call to the psychiatrist at the state hospital brought the caution that if the patient was admitted voluntarily he would most likely request re-

lease within a matter of days. The doctor advised that the patient be committed involuntarily so adequate treatment could be provided.

The father didn't right the decision: neither did he rejoice. Within two hours he was on his way to the state hospital. He was rational and lucid, but not always oriented toward time and place. He still had the power to exercise his will.

Was he falsely committed? Were the prospects for his future probable harm to self and others adequately or wisely assessed? Was he the victim of a family that didn't want to be inconvenienced by his presence? Was there real hope for benefitting him therapeutically? Nothing but the imminent danger to himself and others by his driving a car or setting out aimlessly on foot consciously motivated our decision. The time he is in treatment, i.e., from at least ten days to three months, allows for post-discharge planning by institutional staff and community people.

On the same day, the local inpatient unit of the CMHC discharged a patient at 10:00 a.m. She was 82 years old, had no family, lived alone in a housing project, and was provided "attendant care" by the Department of Social Services. Post-discharge planning had begun by social workers from two agencies in consultation with the nurse on the unit, but it was not completed. Her inpatient treatment was concluded. The doctor terminated her hospital stay. Her bed had to be made available for a possible emergency commitment that night.

The nurse was responsible for informing me at the CMHC that we had the task of arranging for her return to life in the community. After about twenty phone calls, we realized we could in no way make provision for the 24-hour care that would be required. The nurse had to be told that the patient simply must remain in the hospital regardless of the physician's orders. The patient remained. The follow-through was to place her under the care of the Department of Social Services' Protective Care Unit.

This lady had been found unconscious in her apartment by a neighbor. She was rushed to the emergency room of the general hospital. She was placed in the CMHC's inpatient unit. No commitment was required. She went voluntarily. Had she not given consent, the commitment law provided the only viable alternative. She was discharged without a place to go because she refused any placement, e.g., a boarding or family care home, that the DSS social worker was ready to set up for her. Whentime for discharge came, she was incapable of caring for herself alone in her apartment. On the day after remaining the extra night in the hospital, she gave her hesitating consent to go to a family care home. Had she refused that, either the commitment law or the protective service law would have had to be invoked.

This writer believes these case histories illustrate that the quality of care people receive, and a reasonableness of the interpretation of the "immenently dangerous" clause, dominate the commitment scene, contrary to

the accusations leveled by Szasz.

Social Control?

Leifer, an assistant professor of psychiatry, states: "We ought to frankly recognize that psychiatric commitment is a form of social control and not a form of treatment for illness. The humanism of rule of law is based on procedural restraints on the arbitrary exercise of state power; it is only diluted if that power is smuggled in with a psychiatric disguise. If there is a social mandate for the control of certain types of behavior, let it be openly and frankly exercised under the scrutiny of an informed citizenry, rather than covertly as a medical practice."[8]

Amen to the idea that we must not leave commitment to the clandestine operation of the medical profession, but I gainsay that we can leave things to an informed citizenry. The substance of this chapter points to the need for the co-operation of the various professions, legal, psychiatric, psychological, social work, nursing, and the citizenry of patients, family, neighbors, and friends. Together, not alone, good can happen.

There are sufficient examples of inter-agency consultation efforts in cities and counties across the state to make this kind of cooperation no pie-in-the-sky vision. Admittedly, it would be a difficult experiment, but the success of Child Abuse and Juvenile Justice Councils, among

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[8]Robert Leifer, Speech to American Psychological Association, reported in Medical Tribune, (October 1965), p. 1.

others, give reason to hope they could work. Attorneys, physicians, people from the helping professions and laymen meet in these groups for case and program consultations.

False commitment is a tragic mistake that probably can never be totally eradicated from the realm of possibility and probability. False or proper, commitment gives one a "record" that can be more debilitating, harmful and unjust than a criminal one. The 1972 presidential campaign revealed to the public how biased it really is. Having visited a psychiatrist a few times was enough to dump Thomas Eagleton, the vice-presidential candidate, from the ticket.* It is less commitment, false or not, that must be eradicated; it the bias, the misunderstanding, the lack of understanding that must be screened out.

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*Many "enlightened" and "unbiased" people feel that this removal of Eagleton was thoroughly rational, straightforward and justified. Who wants a man who can't handle "stress" successfully to be in a position to handle nuclear bomb decisions? Yet, if we apply the stress argument to one, should not every man be tested before he's elected to the presidency?

CHAPTER VI

DANGEROUSNESS

At the core of the commitment procedure is the judgement of dangerousness by all the principals, viz., petitioners, magistrates, psychiatrists, judges. The word "dangerousness" deserves special consideration with emphasis on the challenge it poses to the physician.

The law traditionally intervenes after the fact, particularly when deprivation of personal freedom is involved. Preventive interventions are repugnant to the law, unless they are associated with what an attorney would call "imminent danger". Involuntary hospitalization is justified by the legal test of "dangerous to himself and others," which is an obvious reference to future behavior. This test fulfills the requirements of the legal model. The psychiatrist, on the other hand, utilizes the medical model which concerns itself primarily with the current clinical state of the patient.

The law requires that the psychiatric recommendation be rephrased into a "legal" statement. The medical statement: "Mrs. Jones is delusional, depressed, and suicidal, and therefore in need of hospital admission" has to be expressed as, "Mrs. Jones is dangerous to herself by virtue of the fact that she is about to kill herself. She has made statements, 'I wish I were dead' etc." Thus, the description

of an illness is translated into a statement about dangerousness. The physician is placed into the unaccustomed role of predicting future events. Though a physician must make prognoses, and sometimes describe the normal future course of a disease, he is, nevertheless, not in the business of predicting, and is ill-advised ever to attempt it with his patients. This is certainly more applicable to the psychiatrist than to the physical doctor. Future acts, motivated by the will, are simply not the arena for man to move in with any assurance that he is doing anything much more than informed guessing. Since the majority of suicidal and homicidal patients do not kill themselves or others, it is erroneously assumed that this proves that they were neither homicidal nor suicidal in the first place. The psychiatrist is then charged with "overpredicting dangerousness."

Imminent danger is a concept which does, legally, justify preventive detention. If one views involuntary hospitalization as preventive detention, then wrongful commitment is, indeed, one of the most rampant social evils prevalent in our society.

Involuntary hospitalization is not identical with preventive detention, although one can recognize some similarities between them. Do these similarities require treating both interventions as if they were identical? There is an ever-increasing body of legal opinion to the

effect that civil and criminal commitments require the same due process safeguards.[1] These involve adversary proceedings, protection from self-incrimination, application of criminal process, evidentiary rules, representation by counsel, and many other safeguards enjoyed by those who are charged with criminal offenses. There are, in addition to similarities, significant differences between preventive imprisonment and involuntary psychiatric hospitalization.

The term "preventive" in the phrase "preventive detention" refers to the anticipation of some behavior which is to be prevented. Is involuntary hospitalization instituted to prevent the occurence of some events, or more specifically, injury to self or others?

From a psychiatric stnadpoint, the answer to this question has to be an emphatic no, though Thomas Szasz maintains the psychiatrist is playing prophet or predictor of future acts. Involuntary hospitalization is not primarily instituted for the purpose of forestalling some future event. Some lawyers and courts have arrived at the conclusion that involuntary hospitalization serves preventive purposes. This assumption lacks empirical evidence. Prevention of injury never was a significant reason for involuntary hospitalization. Specifically, prevention of injury refers to three classes of behavior, namely, suicidal, homicidal, and assaultive. Involuntary hospitalization is used for the care of certain psychotics who are unable to function in the

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[1] See Appendix H, General Statute 122.

community.

Conversation with staff at the local inpatient unit at John Umstead Hospital and at the local CMHC corroborates scientific literature's claims that psychotics who have required hospitalization are not in significant numbers suicidal, homicidal, or assaultive. To the question, is there any evidence that those who attempt to complete suicide are in significant numbers psychotic? the answer is, no, although there is a slightly greater proportion of the "mentally ill" who do succeed. (See Lester and Lester, Suicide: the Gamble With Death) The majority of homicide perpetrators are not psychotic and do not require involuntary commitment to any mental institution.[2]

If the criterion for valid involuntary hospitalization is prevention of homicide and suicide, then the overwhelming majority of patients so hospitalized in the past have been committed for wrongful reasons. Furthermore, if involuntary hospitalization is viewed as a means of contributing to the prevention of homicide and suicide, it is a highly ineffective approach. If every psychotic who by psychiatric criteria requires hospitalization were institutionalized, the homicide and suicide rate would not be significantly affected.

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[2]E. Tanay, "Psychiatric Study of Homicide," American Journal of Psychiatry, 1969, 125:9.

Dangerousness and the Psychiatric Profession

The term "dangerousness" has been appearing prominently in legal literature in conjunction with psychiatry. The Arizone Law Review special project on commitment focussed upon the issue of dangerousness and committability. The authors "prove" by quoting legal scholars that "psychiatrists are rather inaccurate predictors...and even less accurate when compared with other professionals, such as psychologists, social workers and correctional officials, and when compared to actual devices, such as prediction or experience tables."[3]

Psychiatric literature has made little use of the concept of dangerousness. In fact, one is at a loss to fine a psychiatric definition of this term. A survey of psychiatric handbooks, encyclopedias, and contents of forensic books provides few references and little light on the subject. Thomas Szasz does refer to it, saying, "Despite the fact that there is no evidence that mental patients are a greater source of danger to society than non-mental patients, the myth of the 'dangerous mental patient' dies hard."[4]

Legal writers assume that dangerousness is one of the primary criteria utilized by psychiatrists in arriving at a recommendation that an individual requires hospital care. A

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[3]Arizona Law Review: 13: 96, 1971.

[4]Szasz Law, Liberty, and Psychiatry, p. 144.

legal study of Livermore, Malmquist, and Meehl on the "justifications for Civil Commitment"[5] arrives at the conclusion that since we cannot predict future homicidal acts of mental patients with a significant degree of accuracy over non-mental patients, that it is therefore better that no one be incarcerated, lest one suspected person be deprived of liverty. This and like conclusions, are arrived at without reference to clinical reality. These legal scholars approach commitment in terms of involuntary hospitalization from the viewpoint to legal tests, and fail to recognize that recommendations for hospitalization are not based upon legal tests.

The Supreme Court has held that "the due process clause protects the accused against conviction except upon proof beyond a reasonable doubt of every fact necessary to constitute the crime with which he is charged."[6] If mathematical criteria were applied, it would be impossible to convict anyone of crime since mathematical proof would always leave some margin of doubt. Expert witnesses, particularly psychiatrists, are not a special class of witnesses required to give testimony which is mathematically free of the probability of error.

The U. S. Supreme Court held in Johnson vs. Louisiana that: "...less than unanimous verdicts in certain cases are valid under the Due Process and Equal Protection Clauses of

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[5]Livermore, Malmquist, Meehl, "Justifications for Civil Commitment" (U.P.A.L. rev. 75: 84, 1968), p. 99.

[6]Winship, 1970, 397 US 358, 364 (1960).

the Fourteenth Amendment."[7] Johnson pleaded not guilty, was tried by a twelve-man jury, and was convicted by a nine-to-three verdict as provided by the Louisiana Code of Criminal Procedure. "Reasonable Doubt" is a technical legal term and is not to be confused with scientific doubts and differences of opinion.

Judicial decisions have innumerable references to the imperfect state of psychiatry, the inability of psychiatry to predict, to diagnose consistently, etc. Psychiatrists should not assume that their field is particularly cursed with these imperfections. A closer look at any applied science revelas that psychiatry is not unique in this respect. Science, particularly in its applied form, can never achieve the perfection and certainty of the law. Science laks the device necessary for perfection which is utilized in the law, namely, legal fiction. Such concepts as reasonable man, ability to distinguish right from wrong, reasonable doubt, dangerous to himself and others, are examples of such devices utilized in the law. These concepts are accepted as "givens" used with impunity unless legally challenged.

The term, "dangerous to himself or others" is a legal test and not a clinical entity. It does not reflect psychiatric thinking, but represents a legal construct devised for legal purposes. For the psychiatrist, it points to an existential state that requires treatment; for the judges

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[7] Johnson vs. Louisiana, 1962, 406 US 356 (1962).

or jury, it represents a future act. It is a legal criterion for the legal fact-finder (judge or jury) who takes the psychiatric data and determines whether they fulfill in this case the requirements of the law. It is not a psychiatrist who determines the presence or absence of a legal criterion, but the legal fact-finder. The psychiatrist, during the proceedings, is merely a witness. Psychiatry need not feel compelled to endow every legal term with clinical meaning. Involuntary hospitalization has never been viewed by psychiatry as a from of preventive detention, but as a therapeutic intervention. Though the therapeutic aspect is the primary substantive factor in the spychiatrist's evaluation and recommendation for involuntary treatment, it is not to say that the concept of future dangerous acts are far from his mind as he moves toward his determination.

Legal writers have expressed considerable disappointment with psychiatry about its inability to predict dangerousness. The legal profession would even have the psychiatrist state with certainty who is or is not dangerous, as well as when the dangerous act will occur and that it will be associated with "substantial injury". Not even physics could satisfy such expectations, to say nothing of biology or psychiatry. Norbert Wiener pointed out that modern physocs is based on uncertainty and "the contingency of events." "Physics now no longer claims to deal with what will always happen, but rather with what will happen with on overwhelming

probability.[8] The expectation that the psychiatrist can come up with infallible predictions is reminiscent of the writings of the Eighteenth Century mathematician Pierre-Simon de Laplace, whose theories dominated the field of probability in the Nineteenth Century. Laplace held the view that omniscient intelligence could predict the course of nature in minute detail with perfect accuracy. The law often expects the psychiatrist to describe phenomena in terms of Newtonian physics "which described a universe in which everything happened precisely according to law, a compact, highly organized universe in which the whole future depends strictly upon the whole past."[9]

The quality of "dangerousness", even if capable of definition, could only be analogized with some aribtrarily agreed-upon standard. Being suicidal or homicidal is not a characteristic with an all-or-none quality like pregnancy; it is rather comparable to obesity. Therefore, quantitative assessments of "dangerousness" cannot by the very nature of things be made on a yes-and-no basis. Dangerousness, as referring to the likelihood that a person will not care for himself to the extent that grievous harm will occur physically, is also an eventuality that cannot be predicted with mathematical accuracy. But it is an aspect of the total concept of "dangerousness" within the commitment process

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[8]Norbert Wiener, The Human Use of Human Beings---Cybernetics and Society, (New York: Avon Books, 1967) pp. 18, 90.

[9]Ibid., p. 15.

that generally allows for much closer predictability.

Dangerous is an adjective describing a person as harmful from a frame of reference of the classifier. Dangerousness is not a clinical state in itself. Who is dangerous? A senile patient who walks across the street and causes an accident leading to death and injuries? Is a child who runs across the street and causes an accident dangerous? How about the alcoholic who drives recklessly? How about the medical charlatan who gives useless medication, promising cure and delaying realistic treatmsnt?

Danger is an appraisal of a prospective relationship between two or more entities. It is not inherent property of a thing itself. The clinician, not being personally involved with the patient as a real object, views the patient in terms of the patient's own state of being. The patient is neither a source of gratification nor does he represent a real threat to the physician. The question confronting the clincian is not what will the patient do to himself, to the clinician, or whomever, but what is his state of being? It is this kind of soncern that promtps and motivates the action of the psychiatrist in his evaluation and treatment of the committed patient. Szasz has difficulty with this on many counts, but I would submit that it is a rare psychiatrist who evades this basic challenge for which his whole training prepared him. Not the law, but the patient must prevail.

Relatives and patients frequently quote physicians as saying; "Igive him six months to live," or "She will be

dead in three months." Few physicians make such statements, and none should. Psychiatrists are quoted at times as saying: "If you don't commit her today she will kill herself tomorrow," or "The doctor said if I don't sign my husband in, he will kill me and the children." Few psychiatrists make such statements, and none should.

Prediction and Psychiatry

It has been assumed by some that psychiatry is involved with prediction of future events. Neither psychiatric literature nor daily practice or psychiatry justifies such an assumption. Psychiatric opinion that a patient is in need of involuntary hospitalization is confused by some as prediction of dangerousness.

The concept of prediction needs some elucidation and definition. The description of a behavior tendency does not constitute a prophecy of an event. A tendency is a readiness to engage in specified behavior which is inferred from observational or historical data about the patient. Bowlby writes: "Whether the behavior occurs in animal or man, the main reason for inferring the presence of a hidden tendency is that the tendency reveals itself in occasional and incomplete sequences of behavior."[10] The description of a tendency is frequently confused with prediction of a

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[10]J. Bowlby, Attachment and Loss, (New York: Basic Books, Inc., 1969), vol. 1, p. 93.

future event like homicide or suicide. Prediction is defined as: "To state that there will be; foretell."[11] A specialized dictionary has: "A statement about an event with respect to its future outcome. Predictions are usually cast into quantitative form as probabilities with a certain degree of certainty."[12]

The term, "prognosis" in psychiatry makes reference to the future course of an illness either in terms of the illness itself or the particular patient. The term, "prediction has no technical standing in psychiatry, although it is a technical term in various other applied sciences like statistics, survey research and experimental psychology. The medical model does not concern itself with statistical probabilities when dealing with individual patients. A computer prediction based upon trends in horse-driven traffic in the 1870's would have indicated that by 1970 the surface of the globe would be covered by six feet of manure.[13]

Psychiatry is concerned with the presence of clinical states and not the prediction of some future events. Hospitalization of a patient is recommended because the patient is described as being depressed, delusional, suicidal, here and now. The psychiatrist does not offer his recommendation

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[11] Websters New World Dictionary, College Edition, (Chicago: The World Publishing Company, 1964).

[12] J. F. Chaplin, Dictionary of Psychology, (New York: Dell Publishing Co., 1966).

[13] H. Miller, Medicine and Society, (London: Oxford University Press, 1973), p. 14.

primarily upon the claim that some future event, like suicide or homicide will occur. The statements "suicidal" or "homicidal" or "unable to care for self" are not predictions that an event will take place, but a description of a clinical state in the patient here and now. The description deals with the present, and not with any knowledge of the future. Whether a patient will die by his own hand often depends upon factors which may have nothing to do with his state of mind. For example, the patient might make a suicide attempt and survive because his city has an effective emergency care service. The effectiveness of medical care in a given locality is not a function of the psyche and should not be made a criterion of validity of the psychiatric statement about the mental state of the patient. In fact, a psychiatrist will find a confirmetion of the fact that the patient was suicidal when through his efforts the suicidal state is resolved and the patient lives happily ever after.

The concept of dangerousness is too broad to be psychiatrically based. It connotes a qualitative certainty to non-mental health people that results in a false reading of psychiatric evaluations. It simply is not a part of the medical/psychitric usage. The term is vague and adds nothing to the accepted categories of being suicidal and homicidal. As long as a judge does not contaminate his own legal terminology with concepts or meanings falsely attributed to other professions, there may be no trouble. A respondent certainly deserves to have his judge clear on definitions of words that sound like a bell of liberty or a turn of a key.

CHAPTER VII

CONCLUSION

Our vital, all-embracing question is: Is liberty advanced or retarded by our North Carolina laws and practices regarding the commitment of the mentally ill or inebriate?

The Appendix provides a survey of the resources of our local Forsyth County Community and or our region within the state. We have travelled through the labyrinthine ways of the legal and psychiatric processes involved in "serving" the citizens who are disturbed and disturbing. We are now ready to conclude this study with some recommendations that I believe would improve the North Carolina practice of involuntarily committing mentally ill and inebriate persons who pose imminent danger to self or others.

1. The state institutions should be gradually phased out of existence. The General Assembly and the State Department of Human Resources should continue an active campaign to encourage local alternatives to the large state facilities. An admirable start has been made. We find concrete evidence in community programming efforts; in the last ten years, Forsyth County has added the following facilities and programs to its growing list of alternative community-based services: A Rehabilitation House for Women (Department of Vocational Rehabilitation), serving nine residents

at a time for an average of six months' stay; Sheltered Workshop (Department of Mental Health), serving 57 clients (in 1976); Halfway House for model inmates from Women's Prison (Department of Corrections), serving 6 persons; Home for Emotionally Disturbed Youth (Department of Social Services), serving 8 young people; Lighthouse (church-sponsored) serving 40 temporarily homeless men and women in separate residences; Parents Anonymous (begun in 1976) for parents who complusively beat their own children; Recovery, Inc., (begun in 1975) for former psychiatric patients who meet weekly to provide mutual support, serving about 17 people; Family Life Council, Juvenile Justice Council, and the Child Abuse Council (all begun in 1975), inter-agency umbrella organizations of coordination, facilitation, and advocacy; Creative Life Center, Inc., non-profit, serving 20 elderly in day care activity; Friendship Club (Mental Health Association) serves about 15 people who have returned from mental hospitals and need a weekly social activity program to help inadjusting to community life; Residense for alcoholics (Department of Mental Health), provides about 30 men with room, board, and a daily treatment program; Council on Drug Abuse (Foundations and Department of Mental Health), offers 24-hour counseling, outreach, and day treatment to hundreds of people annually; partial (day) hospital (Department of Mental Health) serves 20 patients as an alternative to full hospitalization.

Though continued expansion, refinement and coordination are needed, the above programs are affording the means

to reduce needless and unjustified commitments to a minimum. The scope of actual liberty is being increased. But the county does not posess means of restriction and management for violent patients or for those who cannot care for themselves. The regional facility at Butner is so equipped, as is the State forensic unit in Raleigh. Many a year will probably pass before local communities will be equipped to duplicate their treatment and management capabilities.

In October 1975, Forsyth County had 93 of its residents under care at John Umstead Hospital, not counting alcoholics. Over 75% were committed involuntarily. These patients came from situations where neither their home arrangements nor the local inpatient units could together serve their needs. For some few of these 93, John Umstead Hospital has become home; they do not want to leave. This is mostly due to their not knowing the more homey arrangements of the small group home. Already, the North Carolina psychiatric facilities have been ordered to refuse admission to any person for whom only maintenance and support can be given; yet funding has been so limited that staff cannot provide the "luxury" of psychotherapy for those who would benefit from it, thus leaving chemotherapy as the only available treatment.

So the move is on! The planning process for the final demise of the large institutions should continue and the funds and personnel should be dispersed to the communities for smaller living arrangements.

2. No one should be committed, with subsequent loss of

liberty, without a multi-disciplinary team of professionals and laymen making the evaluation. It should not be left to the medical and legal professions alone.

Human vision is too often limited by education and profession. Human liberty is too precious to be left in the hands of those who are subject to normal human prejudices and other culturally created defects. The best of physicians and judges simply cannot deal with the broad, diverse, complex human needs and the equally complex networks of community resources that might respond to or satisfy those needs. Immediate action is indeed needed to come into play when obvious danger is present and harm would result without intervention. Petition signing, pick-up by law enforcement, immediate psychiatric evaluation, detention in a non-jail holding facility, and the beginning of a treatment process should take place, as it now does. It is during this holding period, before the hearing before the judge, that the committed patients should have the law's mandate of a multi-disciplinary team of experts consulting together to seek alternatives to commitment to a state facility. Social workers, nurses, clergy, community workers would be called to consider the alternatives available in the local community. Outpatient com-mitment is one such alternative now, fortunately, in more common use in this state. At present, the judge is limited to dismissing the case at the hearing, or committing to outpatient or inpatient treatment. Other forms of treatment are possible, but require the insight and knowledge that can only

be posessed by a community-oriented and knowledgeable team. The least restrictive form of treatment that truly meets the clients' health needs should be the guiding principle for maximizing liberty in the face of necessary limitation.

3. There should be a clear indication of the nature and scope of the danger involved in the commitment and expressly stated in the court order.

Currently, the court order merely provides space for a declaration by the evaluating psychiatrist that the respondent is mentally ill or inebriate and is dangerous to self or others. The physician should not be placed in the position of trying to predict dangerous acts. That should be the province of the combined community team: to determine as precisely as possible the nature and extent of the possibilities of danger. The kind of danger needs to be distinguished in terms of homicide, suicide, assaultive behavior, criminal acts, inability to care for one's person in terms of food, lodging, following medical orders, etc. The physician should be left in the position of determining that danger exists as a factor of treatment, not prediction. When the non-medical team presents the judge with its positive assessment of danger, the judge has the best information for his own decision regarding commitment. This relieves the judge of depriving citizens of liberty based on two areas of decision-making in which he has no special competence, viz., medical treatment and behavior-prediction.

4. An outpatient commitment coordinator should be as-

signed to every court handling commitments.

In North Carolina, a hearing must be held within ten days of an order to pick up a respondent for whom a petition has been signed by a concerned person, an order issued by the clerk of court or magistrate, and psychiatric evaluation has been made. Between that initial series of acts and the hearing, a great deal of profitable work can be performed by a social worker that can prevent injustice and set the stage for the most suitable treatment plan. The social worker can perform invaluable casework investigation with the family and relatives of the respondent as well as with the respondent. This worker can coordinate the efforts of the community evaluation team, serve as consultant to the judge at the hearing and to the attorneys preparing their cases, and seek out community alternatives to institutional commitment.

5. The full array of constitutional rights, save trial by jury, should be afforded respondents in the commitment process.

A considerable degree of due process has been introduced into the judicial procedure for committed patients by the General Assembly. Counsel is now provided the respondent along with the right of habeas corpus, judicial review, the testimony of witnesses, cross-examination and hearings. But there are subtle aspects of the law which need finer tuning to fully guarantee the implementation of these fights. Former Representative Howard Twiggs, who introduced the present legislation into the 1973 legislature, has stated at

several public gatherings that the law does not fully insure constitutional rights. He opines that a case testing of the law, rather than a legislative reqriting of it, fill fill in the constitutional lacunae.

The assistant clerk of court in Forsyth County feels that judges would gladly opt for jury trial of commitment cases. He states that the judges think it is either a medical matter that should be left to physicians or one that the citizenry, forming a jury, could handle better than themselves.

Obstacles to due process (jury trial) are time and money. The current process and lack of adequate court personnel would make the purpose of commitment (immediate action toward treatment) unattainable.

6. A post-hearing treatment plan should be elaborated by the treatment team at the inpatient or outpatient facility to which the patient has been committed and given, in writing, to the patient,the judge, the family (or significant others) and to the defense counsel.

North Carolina law now protects a committed patient from being forgotten by all the parties of the commitment process. There is a compulsory 90-days-later hearing, at the place of treatment, at which time the facility treatment team considers the progress of the patient and the appropriateness of either discharge or continued treatment for a maximum of a further 180 days. The patient has the right, again, of defense counsel and other benefits of due process,

minus the right of trial by jury, at this second, and any subsequent hearings.

It is imperative that all the parties to a commitment know the goals and basic methodology of the treatment plan. This can be a guarantee that liberty will be gained at the earliest possible moment. It can tend to focus attention on the site and plight of the patient. There is always the danger that "out of sight" may mean "out of mine". A treatment plan, with the presenting problem clearly defined and delineated, the goal(s) well-defined, and an estimated target date for echievement would serve several purposes. It would keep the family and judge and others apprised of the meaning of their involvement and that the case is not finished simply because danger has been averted or treatment begun.

Final Statement

In November 1975, Georgetown University sponsored a conference on the medical model of mental illness and its role in the involuntary commitment process. Dr. Thomas S. Szasz held firmly to the position he took 20 years previously. The passage of years has not changed any of his fundamental positions. He still manitains that involuntary commitment if "the greatest threat to individual dignity in America."[1] The Clinical Psychiatry News report of the con-

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[1] "Medical Side of Involuntary Commitment Issue Debated, Clinical Psychiatry News, Rockville, Md., (Nov, 1975), p. 1.

ference indicates that Szasz sees mental illness as simply a defamation disguised as diagnosis. He still maintains that persons said to be suffering from mental illness may be socially deviant or in conflict with individuals, groups or institutions, but that they do not suffer from disease. He sees commitment of these patients as serving moral and social purposes, rather than therapeutic ones. Since mental illness is not a contagious disease, there is not medical justification for isolating such patients. He holds that involuntary commitment to protect society from "dangerous" mental patients is actually a means of isolating annoying persons who have not violated laws. Commitment may also be misused to confine lawbreakers who might be freed or given light sentences if tried in a criminal court. He feels that psychiatrists sometimes diagnose the same patient as being either sane or insane, depending on the social demand at the moment. "The vocabulary of psychiatry is inquisitorial, used to stigmatize and vindict," he said.[2] The fact that the American Psychiatric Association's decision no longer to consider homosexuality a disorder is an example of voting to define English. "People who dislike one another call each other mentally ill."[3]

In many states there has been little progress in liberalizing and humanizing the commitment laws. Not so in North Carolina. The Appendix contains the latest laws of

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[2]Ibid., p. 25.

[3]Ibid., p. 25.

North Carolina which show that, for the most part, the citizens of the state are protected from arbitrary action by individual citizens, public agencies, or judges themselves. We are still left with human beings who must implement the law, and history gives testimony that unscrupulous, ignorand or prejudiced individuals can distort and misapply the law. But safeguards are built into the legislation, due process is applicable and appeal and advocacy are available to protect the committed person from injustices.

Justice William O. Douglas, who retired from the Supreme Court of the United States in November 1975, built his philsohpy and practice of law on the supreme value of freedom. A very apt statement from a very different context (Wunderlich in 1951) can be applied to our concern about liberty being enhanced or inhibited by commitment procedures:

> Law has reached its finest moments when it has freed from the unlimited discretion of some ruler, some civil or military official, some bureaucrat. Where discretion is absolute man has always suffered. At times it has been his property that has been invaded; at times, his privacy; at times his liberty of movement; at times his freedom of thought; at times his life. Absolute discretion is a ruthless master. It is more destructive of freedom than any of man's other inventions."[4]

Freedom is usurped when one is unjustly committed to a mental institution. Freedom is in precarious balance when one cannot move about for fear of unjust harm from a person

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[4]Ramsey Clark, "William O. Douglas: Daring to Live Free," The Progressive, vol. 40, No. 1, January, 1976, p. 7.

who lacks control of his/her impulses or is rationally disoriented to time, place, and person. Maintaining freedom s balance will always be difficult among imperfect human beings. Though we should err on the side of freedom, for the individual, if err we must, law must always taks into account the many, as well as the one.

Ramsey Clark, committed to liberty in public and private life, as recent history testifies, offers a masterful paragraph at the conclusion of the just-quoted article. I take it as a fitting conclusion to the concern of this paper:

> In Of Men and Mountains he (William O. Douglas) wrote, "We can keep our freedom through the increasing crises of history only if we are self-reliant enough to be free...We need a faith that dedicates us to something bigger and more important than ourselves." In a 1957 speech at the Columbia Law Review banquet he said, "Faith in America is faith in her free institutions or it is nothing." In Being an American he wrote, "We may never reach perfection in our practice of the ideals of the Bill of Rights. But there is no earthly reason why...it cannot become an increasingly potent force...The extent of a community's respect of the human rights of all...is...the measure of its progress in civilization..." He predicted America's future achievements "will be a monument to the faith of man in man and in the principles of freedom."[5]

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[5]Ibid., p. 7.

APPENDIX A

The Local Resource for Evaluation and Treatment of Forensic Patients

An Overview of the Forsyth/Stokes County Area Mental Health Program.

It was back in 1962 that Congress appropriated funds to assist states in studying their needs and resources as a basis for developing comprehensive plans for mental health programs. In 1963, it authorized a substantial Federal contribution toward the cost of constructing community mental health centers proposed within the framework of state mental health plans.

States and communities readied themselves to try the "bold new approach" called for by President John F. Kennedy to help the mentally ill and, hopefully, to reduce frequency of mental disorders. The core of the plan was to move the care and treatment of the mentally ill back into the community so as to avoid the needless disruption of normal patterns of living, and the estrangement from these patterns, that often come from distant and prolonged hospitalization; to make the full range of help that the community has to offer readily available to the person in trouble; to increase the likelihood that trouble can be spotted and help provided early when it can do the most good; and to strengthen the resources of the community for the prevention of mental disorder.

The community-based approach to mental illness and health attracted national attention as a result of the findings of the Joint Commission on Mental Illness and Health that was established by Congres under the Mental Health Study Act of 1955. After five years of careful study of the nation's problems of mental illness, the Commission recommended that an end be put to the construction of large mental hospitals and that a flexible array of services be provided for the mentally ill in settings that idsrupt as little as possible the patient's social relations in his community. The idea of the comprehensive community mental health center was a logical sequel.

Forensic services have been a small part of the total offered the citizens of North Carolina through CMHCs.* Regional facilities, viz., Dorothea Dix And Cherry Hospitals, located in Raleigh and Goldsboro, respectively, have performed the bulk of psychiatric evaluations, diagnosis, treatment and detention.

The 1975 Assembly of North Carolina Legislature has mandated that the locus of services be changed from near total dependence for forensic services on the Regional and State facilities to the local community. This mandate on forensic services is finally catching up with the original concept that motivated Congress in 1963 to pass the Community Mental Health Center bill.

*CMHC is the abbreviation to be used throughout this text to replace "Community Mental Health Center."

A description of these local CMHC resources follows. It will provide the base for better understanding the issues involved in terms of constraints, expertize and capacity for carrying out mental health services worthy of the forensic patient, defendent or respondent.

The local Area Mental Health Program encompasses Forsyth and Stokes counties which are located in the Northern Piedmont section of North Carolina. Aside from this geographical fact, the two counties are quite dissimilar, yet each has something to offer the other.

Forsyth County, which includes the major manufacturing city of Winston-Salem, had a population in 1975 estimated at 227,000. Approximately 141,000 of this total are residents of Winston-Salem. Whereas about 35% of the city's residents are non-white, only about 3% of those living outside the city are non-white. Population projections indicate that there will be more than 240,000 county residents in 1980. Manufacturing presently accounts for roughly 40% of the annual payroll of $1,000,000,000. With the Greensboro and High Point area, it forms the largest Metropolitan Statistical Area between Washington, D.C., and Atlanta, Georgia.

Stokes County lies directly to the north of Forsyth County, and forms part of the southern boundary of Virginia. It is somewhat larger in area than Forsyth County, has a population approaching 25,000 and is primarily agricultural. Many Stokes residents work in Virginia and Winston-Salem.

In April of 1972, these two counties combined to form

an Area Mental Health Program, the North Central Region's ninth Area Program. Currently the Stokes and Forsyth County Departments of Mental Health provide a full range of services to their residents in and through one Area Program. There are 65 staff positions, at present, with an annual budget just exceeding $1.6 million. The Area Program provides services in the areas of Adult, Adolescent, Children, Alcoholism, Drug Abuse and Mental Retardation categories.

The Comprehensive Alcoholism Program

Federal funds, under the Hughes Bill, were made available to communities in 1970 for the establishment of comprehensive alcoholism programs across the nation. The total appropriation was large because over nine million Americans are addicted to alcohol and over fifteen million people are heavy drinkers. The accident and crime rate owe much to the power of alcohol on human behavior.

Forsyth County received an initial grant of $342,587.00 in 1971 to be used for staffing purposes only. The grant was to continue for eight years on a decreasing basis, matched by state and local funds on an increasing allocation.

Federal requirements for the funding of comprehensive alcoholism programs call for the provision of five essential services to patients within the local community. There are other services which can be provided but the following are necessary.

1) Outpatient. The outpatient clinic serves as the coordinating agent with all affiliate agencies to assure that federal,

state and local requirements are met in the provision of services. Further, it provides medical and counseling services for the alcoholic and his family.

2) Inpatient. The Alcoholic Rehabilitation Unit consists of sixteen beds located on the fourth floor of Reynolds Family Health Center. A full range of hospital services are available to the patient, including detoxification. Patients may be admitted directly to the unit through the resident physician, or, in case of evening emergency and weekend emergency, through one of the local hospital emergency rooms. This unit is the primary holding unit for respondents evaluated as dangerous to self or others and awaiting hearing.

Patients may remain on the unit for approximately ten days, the average time being five days. Mental patients and drug addicts may be held on the unit pending transfers to other facilities.

3) Emergency Services. The emergency room was used at Reynolds Hospital until January, 1973, when the emergency services were moved to Forsyth and North Carolina Baptist Hospitals and referrals for follow-up care are received from the two facilities as well. The Area Mental Health Program contracts with Triad Neuropsychiatric Associates to provide emergency psychiatric coverage.

4) Residential Care. Residential care for men is provided by the Alcoholic Residential Care Authority located at Buxton and Eighth Streets. The facility has fifty-two beds and serves an average of 90--100 men each month. A varied program is available to the men including attendance at religious ser-

vices, A.A., recreational activities, counseling, job placement, linkage with other medical and counseling services within the comprehensive system. There is no equivalent facility for female patients. Referrals are made to existing homes locally and in other counties.

5) Consultation/Education. Three full-time health educators are employed to provide consultation/education services. In addition, all professional staff members participate in this endeavor so that from four to six thousand people per month are exposed to some aspects of the Area Alcoholism Program. These services extend to medical, social, and professional agencies, schools, PTAs, churches, etc.

In addition to the five components, an arts and crafts unit is located on the fourth floor at Reynolds, and serves patients on the Alcoholic Rehabilitation Unit. A second arts and crafts unit is located in the annex of the Mental Health Center and serves outpatients from the different divisions of the Department of Mental Health.

The Forsyth County Mental Health Center for outpatient treatment of adults and adolescents follows the principle that people can have mental and emotional conflicts and disorders best treated in their own community setting.

A full range of services is provided under the following categories:

Crisis intervention on a walk-in basis
Individual psychotherapy
Group therapy
Chemotherapy
Psychiatric evaluation

Psychological testing and evaluation
Inpatient referral
Emergency services
Consultation, case and program to community agencies, institutions.
Education to the public and professionals
Training of community workers
Student field-placement training
Outpatient commitment coordination/treatment
Pre- and after-care
Liaison with John Umstead Hospital
Liaison with the Court, Police, Correctional System.

Durg abuse Services provide individual and group treatment of persons of all ages with drug problems. Preventive education is a major effort of the Drug Abuse staff centered manily in the junior and senior high schools.

The Forsyth County Sheltered Workshop is a "work activities center" operating as the Division of Mental Retardation for the Department of Mental Health.

Vocational evaluation, work adjustment and work activities are the major operating programs. Personal and social adjustment is available as a workshop service to any client who would like to participate. Clients include those persons, age 18 and over, who have a primary diagnosis of mental retardation and/or are in need of the services of the program. Currently, there are eight full-time staff positions filled and a client roster of 60.

Vocational evaluation is a thirty-day structured program consisting of vocational testing, behavioral observation, and individual counseling. Work adjustment is a program of training lasting from two to eighteen months. Ordinarily, work adjustment is available to those clients whose goal is

competitive employment. A behavior modification program with a "token economy" is one of the methods of positive reinforcement used in the program. Vocational training occurs when a specific job has been identified for a client inwork adjustment.

Work activities consists of covered work on a sub-contracting basis and is available for those clients not presently in a diagnostic or training program. These clients are re-evaluated periodically.

Personal and social adjustment is directed toward social and community integration of the client population. Through recreation, educational tours, and similar programs the clients may learn to function in the non-vocational segments of society. As an adjunct to the program, an adult basic education curriculum is being incorporated for those clients lacking such basic skills as telling time, making change, identification of safety signs, etc. Any client may participate in these programs.

By contractual agreement, the Workshop has employed the services of a speech therapist to diagnose, screen, and in individual cases, work on a tone-to-one basis with any client in need of speech and hearing therapy services.

Group Homes of Forsyth, Inc., has contracted with the Area Mental Health Program to establish the first group home for the developmentally disabled adults.

APPENDIX B

The Staff of the Community Mental Health Center and the Treatment Capabilities

Many disciplines are represented on a comprehensive CMHC staff. The core person is the psychiatrist, the psychiatric physician. At the Forsyth County CMHC, the Psychiatrist is on duty full time. Outside the regular business hours, psychiatric consultants are contracted to be on call with the emergency room of the County hospital. During off-hours, the Clerk of Court is obliged to seek psychiatric evaluations for respondents with petitions for their commitment from the non-CMHC psychiatrists.

Most closely aligned with the psychiatrist from the medical side are the Mental Health or Psychiatric Nurses. They are registered nurses who have had academic course work in psychiatric illnesses and on-the-job experience in a treatment environment. Most often, this experience was gained on an inpatient unit of a psychiatric ward. Two Mental Health Nurses are employed at the Forsyth County CMHC. The special importance of their presence on a CMHC staff derives from the widespread use of psychotropic drugs in the treatment of so many symptoms.

The psychologist is the only mental health professional who is trained to give a variety of psychological tests, evalu-

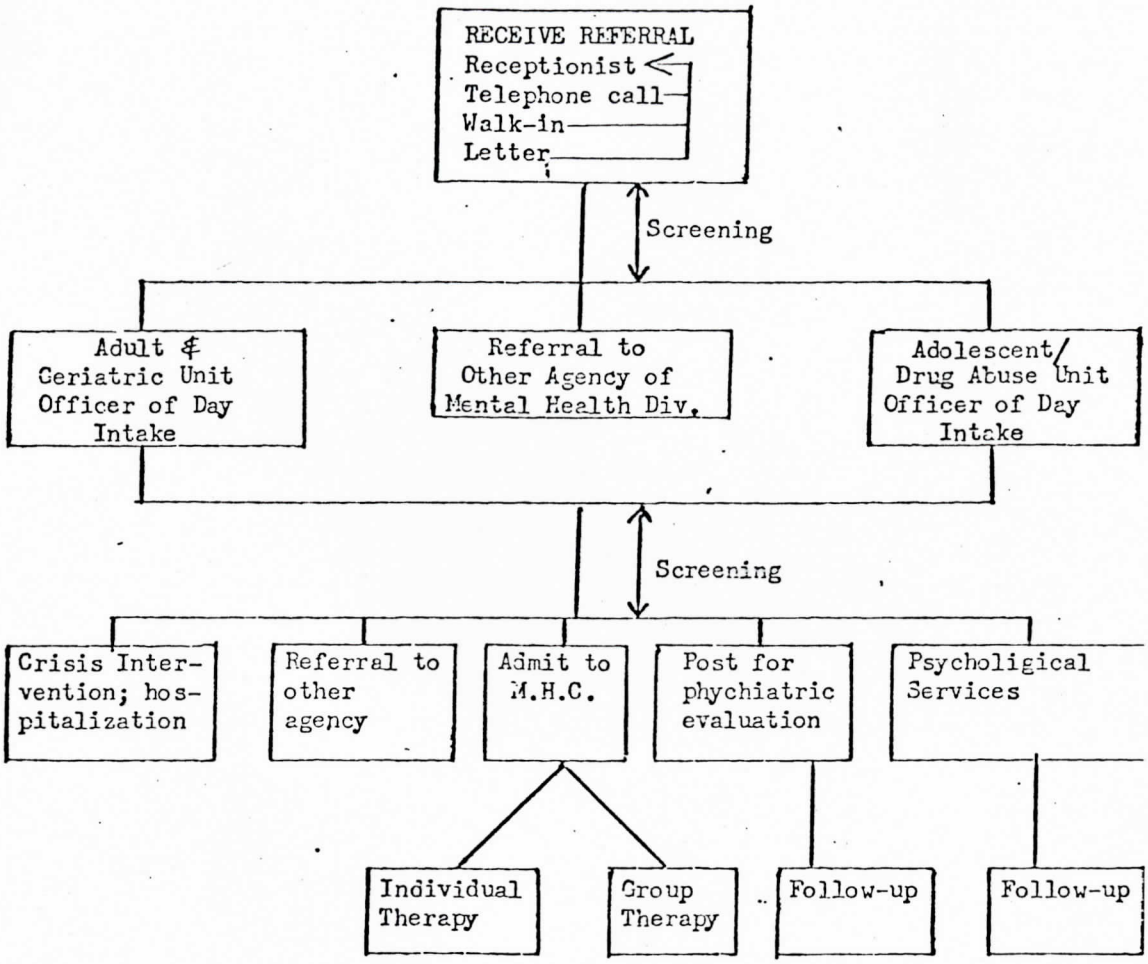
ate them and provide a diagnostic profile for use by the therapist. Their training, as is true of all mental health professionals, enables them to give individual and group therapy. The psychologist is not medically oriented either in training or in treatment. One psychologist is on staff at the Forsyth County CMHC.

The fourth major discipline on a mental health staff is the psychiatric social worker. Their training varies from social case work emphasis to a more general counseling and guidance background. They provide the main source of psychotherapy at mental health centers. They require the close supervision and back-up pf psychiatrists because medication has come to play such an important part of mental and emotional disorders. Five social workers are on the staff of the Adult Service Unit of the Forsyth County CMHC.

Before dealing in a later chapter with forensic services in particular it will be helpful to describe the referral and treatment process at the Forsyth County CMHC. See page for a flow-chart showing the referral/treatment process.

The initiation of treatment can be a phone call, a letter or a walk-in by anyone, whether client, interested party, agency, or court. In forensic cases, the process begins with a court order froma judge, initiated by himself, the clerk of court, or the prosecuting or defending attorneys.

Generally, the receptionist receives this request for service, insures that the request is appropriate for the Adult Services Unit and makes an appointment with a secretary


RECEIVE REFERRAL
Receptionist
Telephone call
Walk-in
Letter
Screening
Adult & Geriatric Unit Officer of Day Intake
Referral to Other Agency of Mental Health Div.
Adolescent/ Drug Abuse Unit Officer of Day Intake
Screening
Crisis Intervention; hospitalization
Referral to other agency
Admit to M.H.C.
Post for phychiatric evaluation
Psycholigical Services
Individual Therapy
Group Therapy
Follow-up
Follow-up

of the Central Admission Team. Basic demographic data and financial information is taken to admit the person formally as a client (patient) of the Mental Health Center. The patient is then interviewed by the Central Intake Social Worker. This meeting generally lasts an hour during which detailed social, family, and medical history is noted. The special object of this intake interview is to obtain from the client a description of the problem as now seen by the client and the goal he or she is seeking to attain to cope with that problem. When client and therapist arrive at a mutual understanding of problem and goal, the therapist, either at that first interview or a subsequent one, devises a treatment plan that the client can accept and follow. It amounts to a non-binding contract between two people mutually concerned about the same problem, but with different talents and experience for solving it. There is present an interplay of professional expertize, human need, obligations and liberty.

Following the intake interview is a staffing session at which all the staff disciplines are represented. The new case is briefly presented, discussed and disposition or assignment of the case made to one of the staff who then becomes the primary therapist of the patient. Later, during treatment, the therapist may bring consideration of the case to another staff conference (case conference) to seek help in conducting the therapy. Also, this primary therapist may consult individually with any one of his/her colleagues.

It is most generally the psychiatrist who is consulted.

After staffing, a primary therapist may, and usually does, schedule the new patient with the psychiatrist for evaluation. This interview provides the therapist with a more accurate diagnosis plus the medical practitioner's insight into the physical and psychiatric medical aspects of the person's total problem. This is vital because only the psychiatrist can prescribe medication which is needed for so many patients, especially in the early stage of treatment.

A therapist may also request psychological tests and evaluation. Often, a psychiatrist will order certain tests to ascertain organicity from organic brain damage and other neurological disorders. The problem is presented to the psychologist who determines the kind and number of tests to be given. The evaluation results are written up and given to the therapist who may then consult with the psychologist or psychiatrist to better refine the treatment plan and form of therapy.

There are a myriad of therapeutic techniques deriving from individuals and 'schools.' They range from the psychoanalytic school, fathered by Dr. Sigmund Freud, through the very objective Behavior Modification school to the more individualistic therapies that bear the names of Transactional Analysis, Reality Therapy, Rational-Emotive Therapy, Conjoint Family Therapy, etc. Most therapists at CMHCs are eclectic; they are familiar with the theoretic frameworks of many

psychotherapies, are committed to no one of them totally, and adapt to their own individual preferences and talents the appropriate aspects of several.

Time-limited psychotherapy is a treatment modality for people in crisis situations requiring only the briefest of support and counseling. It is given to people who need only short-term counseling to overcome a problem that is not too deeply ingrained and complex. Finally, some people need either long-term psychotherapy that may last for years or a therapy that is geared to maintaining a person on medication and which requires a minimum of talking or counseling.

The Diagnostic Manual on Mental Disorders classifies emotional and mental illnesses and disorders under the following broad categories: Mental Retardation, Organic Brain Syndromes, Psychoses, Neuroses, Personality Disorders, Psychophysiologic Disorders, Transient Situational Disturbances, Behavior Disorders of Childhood and Adolescence. Forensic patients, as with the population as a whole, can be labelled with any one or more of these diagnoses.

It is almost always a devastating and demeaning thing to be labelled in any category of human behavior and status. This is always the case with regard to mental and emotional functioning. The medical model of practice, under which mental health treatment is subsumed, calls for diagnosing a patient's mental or emotional condition and fixing a label on it. Federal and State regulations, as well as insurance companies' policies, demand labelling patients according to

the syndromes they exhibit. There is valid reason for this: it provides easier inter-communication among professional personnel; it provides a manageable mode of statistical information; it provides for a system of accountability and monitoring. No self-respecting and respectful clinician would employ the label with the patient or his/her relatives. But the other side of the question is an issue very much in contention. It says, in effect, that the medical (physical) model cannot be applied to the mental, emotional aspects of a person. Values and criteria of personality judgement are not capable of fully, validly assessing a person's constitution and lifestyle. The practice of labelling falsifies the truth about who a person is. Finally, labelling causes a prejudice in the labeller that blinds him/her to the full range of possibilities the labelled person possesses. All this is especially applicable to the criminal defendant and the committed patient. Like a reputation, a label tends to stick to a person as surely as his shadow follows. Treatment is often totally countered and made ineffective if a label becomes an issue of consequence with a patient.

APPENDIX C

State Resources: Dorothea Dix Hospital

One evening in the Fall of 1973 a young North Carolina State student and his girlfriend were studying at a kitchen table in a house located in Cary. Suddenly a bullet pierced the window and the young man was dead.

Within several days another male North Carolina State student was arrested and charged with murder.

A few weeks later the student was sent to the forensic unit at Dorothea Dix Hospital as recommended by the court to determine if he was competent to stand trial for the crime.

The forensic unit is presently admitting such patients at the rate of 850 per year from across North Carolina.

When a person is sent to the Dix forensic unit, three questions must be answered in order to make a recommendation concerning the person's competency to stand trial:

1. Does the individual understand the charges against him?

2. Does he basically understand the consequences of his charges?

3. Is he able to cooperate with his attorney by understand the attorney's function, the judicial process, etc,?

Parenthetically, it should be noted that in years past, no clear distinction was drawn between mental illness

and competency to stand trial. In recent years this distinction has been clarified, and thus it is now possible for a person who has significant mental problems to be found competent to stand trial.

To better understand the procedure at the forensic unit, the various steps will be outlined.

After the individual is arrested and charged with a crime, the question of the accused's competency to stand trial may be raised by the judge deems it appropriate, he signs the order to commit the individual to a mental health facility for evaluation and treatment for a maximum period of sixty days.

The individual is brought under custody by the county sheriff's department to the admission ward at Dorothea Dix Hospital if the local Community Mental Health Center cannot provide the services required. Some counties have no psychiatrist available full time; others, (Forsyth, for example) do not have the non-jail facilities and personnel to cope with specially disturbed or violent defendants.

After initial admission at Dix Hospital, procedures are completed at the main building admitting unit before transfer to the Spruill Building, which houses the forensic unit. The court order is then checked to determine if psychiatric evaluation has been appropriately ordered, according to relevant statutes.

The sheriff leaves after turning over custody of the client to the staff in Spruill. The forensic unit staff is now responsible for custody of the accused throughout the evaluation

and treatment period and must provide security for the patient as he is evaluated and treated by the various facilities at Dix, such as x-ray of physical therapy.

After custody has been accepted by the forensic unit, a psychiatric aide completes certain aspects of the admission procedure. These include the recording of the patient's rights and the fact that information gathered in the unit may be revealed by court order in his trial. Privately owned clothing is stamped for identification and dangerous objects, particularly those of metal, are temporarily removed from the patient's possession.

The patient then receives a physical examination from a physician and a brief mental status examination from a psychiatrist or psychiatric resident. His condition before treatment or medication will be important later as trial evidence.

All the above happens on the first day.

Throughout the period spent in the forensic unit, a variety of staff is available to the client, including psychiatrists, psychologists, nurses, a vocational rehabilitation counselor, recreational therapists, psychiatric aides, social workers and mental health associates.

Twenty-one days is the average length of stay in the forensic unit for court-ordered patients. During this time a social history is complied through interviews with the patient and from information sources such as family, school records, former employees, etc. In addition, a battery of

psychological tests is given to the client including an intelligence test, a personality inventory and a written test prepared by the National Institute of Mental Health to be used as a guide in determining competency to stand trial. Testing for brain damage is also done.

All of the above information is complied and a "staffing" is held. The purpose of this meeting of everyone involved in working with the client is to bring all of the opinions and information together and to finalize recommendations. Attending this meeting are representatives from all of the various disciplines who have been involved in testing, treating and counseling. The product of the meeting is a report that is sent to the patient's attorney and the district attorney. A copy of this report is also sent to the mental health center in the client's home county.

At this point the forensic unit has completed it's service to the court-ordered client and the sheriff's department is called to return the patient to the county in which the charges originated. However, a staff member may be called to testify in court concerning opinions about the client.

Although the judge considers the report from the forensic unit and also possible testimony, it is his responsibility to reach the final conclusion and to rule regarding the suspect's competency to stand trial. The forensic unit serves as a source of diagnostic impressions and recommendations about capacity to stand trial.

In addition to the question of competency, two other

considerations are raised:

1) Was the suspect criminally responsible at the time of the alleged crime, that is, did he know the nature of his actions?

2) What kind of treatment or rehabilitation does the individual need?

The first question of criminal responsibility at the time of the alleged crime is the most difficult to answer. The final determination of an individual's responsibility is made by the jury, although mental health staff members serve as expert witnesses and consultants to the court on this question. The reliability or accurateness of recommendations about the question is affected by several factors. Included is information abailable to the clinician concerning the client's behavior in the community and at the scene of the alleged crime, details of the alleged crime, the client's behavior in the local jail, and his behavior and mental status during the time of observation.

If the client is found incompetent to stand trial, he will stay at the forensic unit until the charges are disposed of or until he becomes competent. Prior to the 1972 Supreme Court decision of Jackson v Indiana, an individual could remain in a forensic unit indefinitely, solely on the basis of his incompetency to stand trial. The Supreme Court has ruled that a person may be detained in a mental hospital because he is incompetent to stand trial only for a reasonable amount of time (1) to restore the person to competency or (2)

to determine that he is, in all probability, never likely to become competent to stand trial.

If the latter is the case, then the individual must be committed under the usual mental health statutes and meet criteria for civilly committed patients.

Since the forensic unit has implemented this Supreme Court decision, the census at the forensic unit has been reduced significantly.

Each of the three wards in the unit has a fully active patient government program which provides for patient input into the everyday operation of the wards. Programs available to the patient include vocational evaluation, prevocational training, job placement, therapeutic workshop, art and recreational therapy, chemotherapy, and accredited academic work.

APPENDIX D

The Forensic Population: A Psychologist's Data

Highly revealing data about the characteristics of a forensic population are summarized in the Talbes in this chapter. They are extracted from a "Psychological Services Report" compiled by mimbers of the Dorothea Dix Hospital staff. The report represents data accumulated on 416 patients admitted to the Forensic Unit between July 1, 1974 and March 30, 1975.

This data is significant in assessing our local CMHC's capacity to treat forensic patients or in evaluating legal-psychiatric relationships that affect the mentally ill defendant or criminal or respondant.

We will first overview the important information the Tables convey; following that will be a discussion of the interpretations clinicians and others concerned with forensic patients might make.

Table 1 shows that 95% of the forensic population is male, 5% female. Over one-half (56%0 are white, with 44% black. Twenty-four percent of all patients are under 21 years old. The mean age is 29 with an average 9th grade level of school attendance.

Marital status is depicted in Table 2 where 50% of females and 28% of males are shown as married. Separation and

FIGURE

1

Frequency Distribution of IQ's
of Forensic Population Using
APA Intelligence Classifications (N = 409)

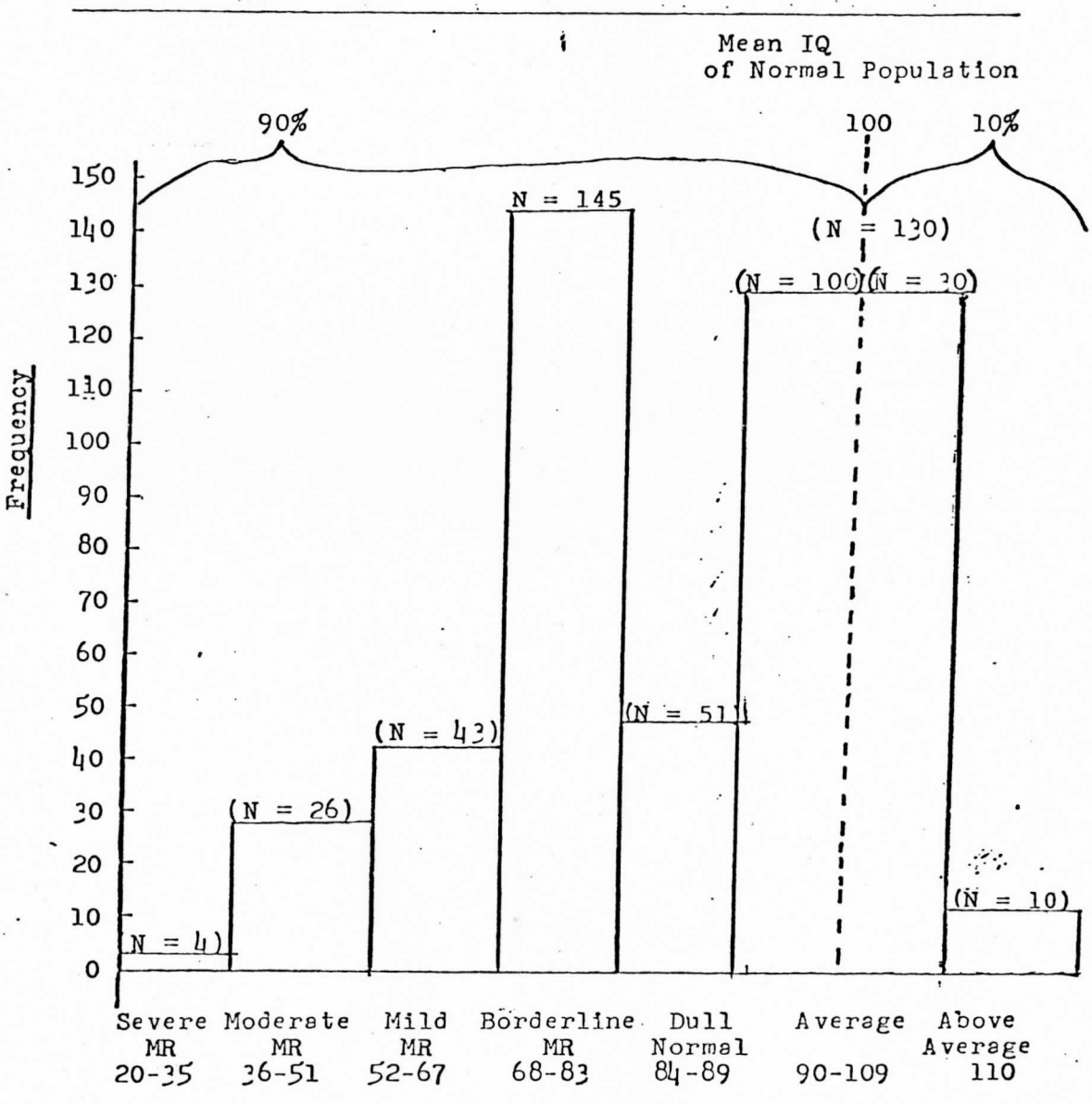


TABLE 1

General Characteristics of the Population

Characteristics	Values
Percent Male	95
Percent Female	5
Percent White	56
Percent Black	44
Percent Under 21 yrs. of age	24
Mean Age	29.2
Mean Reported Grade Level Achievement	9.2

TABLE

2

Marital Status of Forensic Population
on Admission to Dorothea Dix Hospital

Characteristics	Values	
	Female	Male
Percent Married	50.0	28
Percent Single	22.7	52
Percent Separated	4.5	11
Percent Divorced	4.5	6
Percent Widowed	18.2	3

divorce occur in 9% of marriages for the female population and 17% of the male population.

In Table 3 we see that at least one-fourth of the forensic patients are employed in either semi-skilled or unskilled jobs. Only 2% held professional level positions. Unemployment of forensic patients was 12% (October 1974) when the North Carolina civilian labor force had a 4.6 unemployment rate.

Further analysis indicates that some 40% of forensic patients lack marketable job skills (this includes the 12% unemployed figure).

Table 4 presents data on legal charges brought against forensic patients, nearly one-half of whom committed assaultive offenses against persons in the form of murder, rape, robbery and aggravated assault.

Table 5 reveals that 61% of assaultive crimes are committed by individuals under the age of 34. This age group is responsible for 74.8% of major offenses against property. Sixty-four percent of all other crimes, as identified by the North Carolina Uniform Crime Code Report, are committed by the under-31 age group. This is in keeping with the national crime statistics that show the younger adults and adolescents commit the highest percentage of crimes.

Table 6 and Figure 1 combine to show that 90% of forensic patients in the population tested fall below the 100 average IQ mark. Fifty-two percent of this population is

TABLE
3

Comparative Occupational Distributions between a Forensic Patient Sample (N = 135) and Total North Carolina Civilian Labor Force*

Occupation	frequency values	
	Forensic Sample	N.C. Civilian Labor Force
Percent Professional, Technical, & Kindred	2	10.6
Percent Managers, Officials, Proprietors	2	7.2
Percent Clerical	2	13.5
Percent Sales Workers	2	5.8
Percent Craftsmen, Foremen	17	13.9
Percent Operatives	26	25.3
Percent Private Household Workers and non household Service Workers	19	10.6
Percent Laborers, Except Farm and Mine	9	4.9
Percent Unknown	8	3.8
Percent Unemployed	12	4.6

*"North Carolina Interim Manpower Projections to 1980." Data is based upon 1970 Census occupational employment levels which have been projected to 1980.

TABLE

4

Legal Charges of Patients Committed to Forensic Program for Evaluation

Crime	Male (N = 394)	female (N = 22)
Percent Assaultive Offenses	42	49
Percent Major Offenses Against Property	29	13
Percent Other Offenses	29	38
Total	100	100

Assaultive Offenses = murder, rape, robbery, aggravated assault; Major Offenses Against Property = larceny, breaking and entering, auto theft; Other Offenses = all other crime categories cited by N. C. Uniform Crime Code Report.

TABLE
5

Distribution of Crimes of Forensic Patients Across Age Categories

Crime	Age Categories										
	< 20	20-35-	26-30	31-35	36-40	41-45	46-50	51-55	56-60	> 60	Totals
Assaultive Offenses	21 (11.7)	55 (30.6)	34 (18.9)	15 (8.3)	18 (10.0)	11 (6.1)	6 (3.3)	10 (5.6)	3 (1.7)	7 (3.9)	180
Major Offenses Against Property	44 (34.6)	38 (30.0)	13 (10.2)	10 (7.9)	6 (4.7)	5 (3.9)	5 (3.9)	5 (3.9)	1 (1.7)	0 (0)	127
Other Offenses	19 (20.0)	21 (22.0)	21 (22.0)	12 (12.6)	7 (7.4)	5 (5.3)	4 (4.2)	3 (3.2)	0 0	3 (3.2)	95

TABLE
6

Description of Forensic Patient Population
by Intelligence Test Data (N = 409)

Intelligence Quotient	Distribution	
	Percentages	S.D.
Above Average (≥110)	2.4	7.5
Average	31.7	4.9
Dull Normal	12.4	1.5
Mentally Retarded	53.3	12.7
Borderline Retarded	35.4	
Mild Retarded	10.5	
Moderate Retarded	6.3	
Severe Retarded	1.0	

mentally retarded, the majority of which (34.65) fall into the borderline range of retardation (68--83 IQ).

A striking thing is shown by Talbe 7 in that 40% of a sample (N=125) tested for brain damage showed positive evidence of neurological handicap. This is far and away above the average for any random sampling of the general population.

The psychiatric diagnoses of a sample of 137 forensic patients tested over the nine-month period covered by the tests are presented in Table 8. These diagnoses have been taken from the American Psychiatric Association code classifications. Nearly one-half of the patient sample (43%) were diagnosed Without Psychosis; 32%, Personality Disturbance; which includes patients with alcoholic and/or drug dependency; while 16% were diagnosed, Psychosis. The remaining 7% were diagnosed with a variety of psychiatric illnesses such as neurosis, organic-nonpsychotic and transitional situational disturbance.

Of 137 forensic patients presented previously in Table 8, 51% are shown in Table 9 to have psychotic profiles on the MMPI, 34% revealed a personality disturbance profile, while the remaining 12% showed a combination of neurotic, normal or indeterminate characteristics.

A comparison of the Tables (8 and 9) shows that of the 51% who presented themselves as psychotic on the MMPI, only 16% of the sample had been identified by psychiatric diagnosis. Of the 34% identified with personality disturbances on the MMPI, 32 % of the sample received a psychiatric diagnosis of the same.

TABLE

7

Assessment of Brain Damage in Forensic Patient Sample
Applying Russell Scoring System
of the Reitan-Halstead Neuropsychological Test Battery

Evidence of Brain Damage	Frequency N = 125	Percentage
No Brain Damage	75	60.0
Brain Damage	50	40.0
Mild Brain Damage	14	11.2
Moderate Brain Damage	30	24.0
Severe Brain Damage	6	4.8

TABLE

8

Psychiatric Diagnoses for Sample of Forensic Patients

Primary Psychiatric Diagnosis Category	N = 137 frequency	percentage
Psychosis (OBS or Non OBS) (DSM II Numbers: 295, 296, 298, 291, 293)	2	16
Neurosis (DSM II Number: 300)	2	1
Personality Disturbance (Alcoholics/Drug Dependents DSM II: 301, 302, 303, 304, 307, 308, 316)	44	32
Without Psychosis (DSM II: 319.80)	60	43
Mental Retardation (DSM II Number: 310.90)	1	1
Transitional Situational Disturbance	2	1
Organic, Non Psychotic	3	2
Behavior of Adolescence	1	1
Social Maladjustments	1	1

TABLE

9

MMPI Protocols for Sample of Forensic Patients*

MMPI Profile Pattern	N = 137 frequency	percentage
Psychosis	70	51
Neurosis	11	8
Personality Disturbance (Characterological Profile)	47	34
Normals	4	2
Indeterminate	5	2

*Classification of profiles have been determined by Lachar Manual, MMPI: Clinical Assessment and Automated Interpretation.

There are considerable differences in the identification of psychosis, whereas there is marked similarity on the identification of personality disturbances.

Table 10 refers again to differences between MMPI psychotic profiles and psychiatric diagnoses of psychosis. Of 137 valid MMPI protocols, 70 had psychotic code-types, but only 14 of these received a psychiatric diagnosis of psychosis. This shows 56 patients with psychotic profiles on the MMPI but none from psychiatric diagnosis. Also, 67 patients received a non-psychotic indication from the MMPI and 60 of these were diagnosed psychotic bt a psychiatrist. There appears to be marked agreement of the identification of non-psychosis, excluding 7 cases. Forensic psychiatrists, based on this very limited study, tend to use the MMPI to eliminate psychosis but not to diagnose psychosis!

TABLE
10

Comparison of Psychotic MMPI Protocols
with Psychiatric Diagnosis of Psychosis

	Psychotic MMPI	Non-Psychotic MMPI	Total
Psychiatric Diagnosis of Psychosis	14	7	21
Psychiatric Diagnosis of Non-Psychosis	56	60	116
Total	70	67	137

APPENDIX E

Modernizing Forensic Services

To improve forensic services Community Mental Health Centers must follow the general plan of mental health care approved by the State Department of Mental Health and Kept updated by changes that accord with new legislation and local needs. The stress in forensic services is now on community mental health resources as contrasted with the former near-total reliance on regional or state facilities. The current focus is on promoting mental health and less on treating mental illness.

Until the past decade, the focus of forensic psychiatry has been the competency issue with little emphasis on assessing the needs of offenders committed for treatment. Consequently, contact between the mental health system and the legal system has been very limited. However, within the last decade, court decisions such as Jackson vs Indiana and Wyatt vs Sticknew (the patient's Rights and Right to Treatment Issues) have forced the mental health system and legal system closer together in terms of recognizing individual offender rights. Cooperation among judicial, law enforcement, correctional and mental health systems is sorely needed to ensure that forensic patients receive the treatment they need and maintain their civil rights

while in the forensic facility. The mental health system can no longer act solely as a judicial agent where it just confines people over a long period of time without due process of law.

These recent court decisions along with recent changes in North Carolina's General Statutes which pertain to forensic patients as well as the competency standards which have been simplified to expedite process of law have all forced the State's forensic units to assume a more active role with regard to the various agencies. These changes have resulted in a reduction in the patient population at the Dorothea Dix Psychiatric Hospital from around around two hundred and seventy to one hundred twenty; at Cherry Psychiatric Hospital, the reduction is from one hundred twenty-five to eight-four over the last two years.

With these changes, competency is no longer the central issue in forensic psychiatry. The psychiatrist must assume a much wider role in the future than strictly the courtroom appearance. In fact, forensic psychiatry is no longer an appropriate title for the field. Perhaps, a better term is social-legal psychiatry---an idea that suggests that the current issues in forensic psychiatry are no longer the purview of the psychiatrist alone, but represent an inter-disciplinary field.

The focus of intervention must now be seen in a much more comprehensive manner than in the past, thus making the competency evaluation of the defendant only a small part of the mental health's intervention. The defendant's legal situ-

ation becomes an occasion for the community to find effective ways of intervening in the defendant's behalf. A network of professionals from the various disciplines needs to be developed in order to intercept admissions and channel them into the appropriate treatment program. Since mental health stresses the development of community resources, the CMHC should be the primary target and agent in developing this network of forensic services since ideally, the CMHC is in the position to most effectively intervene. The present forensic system operated by the Division of Mental Health has the following elements:

1. Varying degrees of consultation to the judicial, law enforcement and correctional systems at the state and local levels.

2. A complete competency evaluation program at Dorothea Dix Hospital.

3. Custody and treatment at Dorothea Dix for the following types of persons: a) persons found incompetent to stand trial; b) persons found not guilty by reason of insanity; c) persons from the other regional psychiatric hospitals who are non-forensic but who provide management problems. Broughton Hospital currently operates a high-control unit and refers to the forensic unit at Dorothea Dix only its most severe cases. d) Some forensic patients are located in other units of the hospitals that better meet their needs. This is accomplished by joint agreement between the receiving unit and the forensic unit.

Most nationwide forensic systems have been reactive rather than proactive. The followinf factors have increased and will continue to increase the forces for change within the mental health system.

1. A shift from treating mental illness to promoting mental health.

2. A shift from an institutional base to a community base in the delivery of services.

3. The increased emphasis on due process of law for mental patients.

5. The need of patients and agencies in the judicial, law enforcement, and correctional systems for increased mental health services.

6. The realization that most patients in the current forensic system could be handled as well or better in the local programs.

7. Legislation passed by the 1973 session of the General Assembly relating to pre-trial criminal procedures. The general statute was amended with the passage of Chapter 15-A entitled "Criminal Procedures Act", subchapter 10, article 56, entitled "incapacity to Proceed".

APPENDIX F

State Mandate On
Provision of Forensic Services
by Community Mental Health Centers

STATE OF NORTH CAROLINA

DEPARTMENT OF HUMAN RESOURCES

DIVISION OF MENTAL HEALTH SERVICES

JAMES E. HOLSHOUSER, JR.
GOVERNOR
DAVID T. FLAHERTY
SECRETARY

ALBEMARLE BUILDING
325 N. SALISBURY ST.
RALEIGH, N. C. 27611

NAKHLEH P. ZARZAR, M.D.
DIRECTOR

February 13, 1975

M E M O R A N D U M

TO: Local Program Directors and Area Board Chairmen

FROM: N. P. Zarzar, M.D. and the Regional Directors

RE: FORENSIC SERVICES

In the fall of 1973, after careful study of the Governor's Efficiency Study Committee report, the Division of Mental Health Services established the state program of forensic services under the direction of a state director and an assistant director with four regional administrators or forensic specialists to serve the four mental health centers and directed the staff of forensic services to design a program to accomplish this goal.

At this point and time in the development and implementation of a statewide system of community based forensic services, we feel each local mental health program should be engaged in the following forensic services:

1) providing direct services, consultation, and education on an agency and case basis to law enforcement, judicial, and correctional systems;

2) developing an evaluation process geared to the individual centers' capabilities for pre-trail and pre-sentence examinations;

3) designing strategy to serve as a "portal of entry" for all forensic referrals from the area;

4) working with other local community agencies and organizations, and participaing in the development of a program of pre-trial diversion from the criminal process;

5) participating in the development of guidelines and standards for ever-improving forensic services.

For your information, we are enclosing part of the Criminal Procedure Act, which was ratified April 11, 1974 in the second session of the 1973 General Assembly and which becomes effective July 1, 1975. The particular portion of the bill we enclose is Sub-chapter 10, Article 56, "Incapacity to Proceed."

While many local programs have developed ongoing relationships with the criminal justice system and are delivering various kinds of forensic services, we feel it is important that all local program have a plan to be engaged in activities to insure that the judiciary, defense attorneys, probation and parole, law enforcement and other agencies have the necessary help and advice in acquiring mental and psychiatric services for their clients.

The forensic services staff has been directed, and they possess the necessary skills, to assist you in the planning and carrying out of your programs. Please send your area's plan to your Regional Office by March 30, 1975.

Below is a list of Regional Forensic Specialists who are housed at the Regional Mental Hospitals:

Mike Rieder - South Central Region 829-2180

Wayne Breedlove - North Central Region 575-7576

Rod O'Connor - Western Region 704-433-2522

Jack Allen - Eastern Region 735-4121

cc: James W. Osberg, M.D., Deputy Director of Mental Health Services
Robert L. Rollins, M.D., Director of Forensic Services
Bill Hales, MPH., Assistant Director ofForensic Services.

Enclosure

APPENDIX G

Proposed Forsyth/Stokes Area

Plan for Forensic Services

DEPARTMENT OF MENTAL HEALTH

Dennis P. Magovern
ADMINISTRATOR

FORSYTH COUNTY

March 17, 1975

MEMORANDUM

TO: Division Coordinator

FROM: Dr. George Hamilton, Jr.
Area Director

RE: Proposed Forsyth/Stokes Area Plan For Forensic Services

1. All divisions of Forsyth/Stokes Area are currently providing direct services, consultation, and education on an agency and case basis to law enforcement, judicial, and correctional systems. Direct services are provided at the clinics in Forsyth and Stokes and at the in-patient unit at Reynolds Memorial Hospital.

2. All divisions of Forsyth/Stokes Area are currently evaluating patients for pre-trial and pre-sentence examinations on request. Evaluations can be scheduled on either an in-patient or out-patient basis. Security remains the responsibility of the referring agency since our in-patient facility includes only an unlocked ward. All evaluations are performed under the supervision of a psychiatrist where required by law.

3. The Mental Health Clinic in Forsyth and Stokes Counties serve as "portals of entry" for their respective counties. All forensic referrals should be made to the appropriate clinic.

4. The Area Department of Mental Health stands ready to work with other local agencies and organizations in the development of programs of pre-trial diversion from the criminal process.

5. The Area Department of Mental Health is prepared to participate in the development of guidelines and standards for ever-improving forensic services.

GEH/lw

P.S. Please discuss this with your staff and let me have any recommendations by 3/30/75.

APPENDIX H

North Carolina General Statutes 122-55: Patients' Rights

Part 2. Patients' Rights.

§ 122-55.1. Declaration of policy on patients' rights. — It is the policy of North Carolina to insure to each adult patient of a treatment facility basic human rights. These rights include the right to dignity, privacy, and humane care. It is further the policy of the State that each treatment facility shall insure to each patient the right to live as normally as possible while receiving care and treatment. (1973, c. 475, s. 1; c. 1436, s. 1.)

Cross References. — For definitions applicable to this Part, see § 122-36. As to rights of minor patients, see §§ 122-55.13, 122-55.14.

Editor's Note. — The 1973 amendment inserted "adult" near the middle of the first sentence.

§ 122-55.2. Patients' rights. — (a) Each adult patient of a treatment facility shall at all times retain the right to:

(1) Send and receive sealed mail, and have access to writing material, postage, and staff assistance when necessary;

(2) Contact and consult with legal counsel and private physicians of his choice at his expense.

(b) Except as provided in (d) below, each adult patient of a treatment facility shall at all times retain the right to:

(1) Make and receive confidential telephone calls, provided that all long distance calls shall be paid for by the patient at the time of making the call or made collect to the receiving party;

(2) Receive visitors between the hours of 8:00 A.M. and 9:00 P.M. for a period of at least six hours daily, two hours of which shall be after the hour of 6:00 P.M.;

(3) Make visits outside the institution unless such patient was committed

APPENDIX I

North Carolina

General Statutes 122-56;58

Voluntary/Involuntary Commitment

to a treatment facility under Article 11 of Chapter 122 of the General Statutes;

(4) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;

(5) Keep and use his own clothing and personal possessions;

(6) Communicate and meet under appropriate supervision with persons of his own choice, upon the consent of such persons;

(7) Participate in religious worship;

(8) Keep and spend a reasonable sum of his own money;

(9) Retain a motor vehicle driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes;

(10) Have access to individual storage space for the patient's private use.

(c) Each adult patient of a treatment facility shall retain the right to exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, and marry and obtain a divorce, unless such patient has been adjudicated incompetent under the provisions of Chapter 35 of the General Statutes and has not been restored to legal capacity; provided, however, that this Part shall not be construed as validating the act of any patient who was at the time of the Part in fact incompetent.

(d) No right enumerated in subsection (b) above may be limited or restricted without a written statement in the patient's treatment or habilitation plan which indicates the detailed reason for such a restriction or limitation. No restriction of rights shall be made except by mental health or mental retardation professionals responsible for the formulation of the patient's treatment or habilitation plan. In each instance of restriction of rights, the patient's next of kin or guardian shall be given written notice of the restriction and the reason therefor. A written restriction shall be effective for a period not to exceed 60 days and shall be renewed only by a written statement entered by a mental health or mental retardation professional in the patient's treatment or habilitation plan which indicates the reason for such renewal of the restriction. In each instance of renewal of a restriction, the patient's next of kin or guardian shall be given written notice of the renewal of the restriction and the reason therefor. The right to receive visitors and to make visits outside the facility shall be subject to reasonable written regulations imposed by the director of the facility and approved in writing by the Secretary of the Department of Human Resources to prevent passage of contraband to patients; provided, however, that no restriction may be placed upon the right of any patient to communicate with an attorney of the patient's choice, to have that attorney visit with him and, with the consent of the patient, to have the attorney provided with copies of all pertinent records and information relating to the patient. (1973, c. 475, s. 1; c. 1436, ss. 2-5.)

Editor's Note. — The 1973 amendment inserted "adult" in the introductory language in subsections (a) and (b) and near the beginning of subsection (c), deleted "the patient and" preceding "the patient's next of kin" and "and the Secretary of Human Resources" following "guardian" in the third and fifth sentences of subsection (d), substituted "60 days" for "30 days" and deleted "detailed" preceding "reason" in the fourth sentence of subsection (d) and added the last sentence of subsection (d).

§ 122-55.3. Use of physical restraints or seclusion. — Physical restraints or seclusion of a patient shall be employed only when necessary to prevent danger of abuse or injury to himself or others, or as a measure of therapeutic treatment. All instances of such restraints or seclusions and the detailed reasons therefor shall be recorded in the patient's habilitation or treatment

plan. Each patient who is restrained or secluded shall be observed frequently and a written notation of such observation shall be made in the patient's treatment record. (1973, c. 475, s. 1.)

§ 122-55.4. Use of corporal punishment. — Corporal punishment shall not be inflicted upon any patient. (1973, c. 475, s. 1.)

§ 122-55.5. Declaration of policy on right to treatment. — Each patient shall have the right to treatment including medical care and habilitation, regardless of age, degree of retardation or mental illness. Each patient has the right to an individualized written treatment or habilitation plan setting forth a program which will develop or restore his capabilities. (1973, c. 475, s. 1.)

§ 122-55.6. Right to treatment. — Each institutionalized patient shall have the right to receive appropriate treatment for mental and physical ailments and for the prevention of illness or disability. Each patient within 30 days after admission shall have an individual written treatment or habilitation plan formulated by the treatment facility's mental health or mental retardation professionals. Each patient who has been institutionalized in a State hospital shall have, as soon as practical but not later than the time of discharge, an individualized written postinstitutionalization plan setting forth a program of recommended vocational counseling or outpatient care. A copy of such plan shall be furnished to the patient or his guardian and, with the consent of the patient, to his attorney and his next of kin.

Each patient shall have a right to be free from unnecessary or excessive medication with drugs. Such medication shall not be used as punishment or discipline. No medication shall be administered except upon a written order of a qualified physician. Treatment involving electroshock therapy, the use of experimental drugs or procedures, or surgery, other than emergency surgery, shall not be given without the express and informed written consent of the patient if competent, otherwise of the patient and guardian as hereinafter defined, unless the patient has been adjudicated an incompetent under Chapter 35 of the General Statutes and has not been restored to legal capacity, in which case express and informed written consent of his guardian or trustee appointed pursuant to Chapter 35 of the General Statutes must be obtained. Such consent may be withdrawn at any time by the person who gave such consent. Except in case of transfer for emergency surgery, no patient shall be transferred to another treatment facility without receiving reasonable written notice which shall include the reason for the transfer. Such notice shall be given to the patient and to the next of kin or guardian of the patient. (1973, c 475, s. 1; c. 1436, ss. 6, 7.)

Editor's Note. — The 1973 amendment rewrote the first paragraph and deleted "patently" preceding "competent" near the middle of the fourth sentence of the second paragraph. In directing the deletion of the word "patently," the amendment referred to "line 6 of the second paragraph." The reference was plainly to line six of the paragraph as set out in the 1973 Cumulative Supplement, rather than in 1974 Replacement Volume 3B.

§ 122-55.7. Right to civil remedies. — All patients except those adjudicated incompetent under Chapter 35 of the General Statutes and not restored to legal capacity, shall retain the same rights as any other citizen of North Carolina to bring civil actions. (1973, c. 475, s. 1.)

§§ 122-55.8 to 122-55.12: Reserved for future codification purposes.

ARTICLE 4.

Voluntary Admission.

§ 122-56: Repealed by Session Laws 1973, c. 723, s. 2.

Editor's Note.—The repealed section was amended by Session Laws 1973, c. 673, s. 14.

§ 122-56.1. Declaration of policy.—It is the policy of the State to insure that the admission of any person with mental illness to a treatment facility shall be implemented under conditions that protect the dignity and rights of the person; to establish procedures which promptly respond to the needs of the person; to encourage the utilization of voluntary admissions to programs and treatment facilities; and to assure that any person admitted to inpatient treatment facilities is discharged as soon as a less restrictive mode of treatment is appropriate. (1973, c. 723, s. 1.)

Under the Provisions of Art. 4, Chapter 122, N.C.G.S., effective May 23, 1973, a Minor May be Vountarily Admitted to a North Carolina Treatment Facility Upon His Parents' Request but Without His Consent.—See opinion of Attorney General to Mr. R. G. Frye, Jr., 43 N.C.A.G. 161 (1973).

Articles 4 and 5A, c. 122, N.C.G.S., Do Not Revoke the Authority Which G.S. 7A-286(6) Vests in a District Court Judge Exercising Juvenile Jurisdiction to Secure Placement of a Juvenile Needing Residential Care and Treatment for Mental Impairment in an Appropriate Facility.—See opinion of Attorney General to Mr. R. Patterson Webb, Division of Mental Health, Department of Human Resources, 43 N.C.A.G. 163 (1973).

§ 122-56.2. Definitions.—(a) The words "mental illness," as used in this Article, shall mean "mental illness" as defined in G.S. 122-36(d) and "inebriety" as defined in G.S. 122-36(c).

(b) The word "person," as used in this Article, shall mean the person seeking voluntary admission to a treatment facility.

(c) The words "qualified physician," as used in this Article, shall have the same meaning as defined in G.S. 122-36(f).

(d) The words "treatment facility," as used in this Article, shall mean any hospital or institution operated by the State of North Carolina and designated for the admission of any person in need of care and treatment due to mental illness or mental retardation, any center or facility operated by the State of North Carolina for the care, treatment or rehabilitation of inebriates, and any community mental health clinic or center administered by the State of North Carolina, and, provided that approval of admission is obtained from the Director of the Inpatient Service, the Psychiatric Training and Research Center at the South Wing of the North Carolina Memorial Hospital at Chapel Hill for admission or commitment to that facility. (1973, c. 723, s. 1.)

§ 122-56.3. Procedure for voluntary admissions. — (a) Any person who believes himself to be in need of treatment for mental illness may seek voluntary admission to a treatment facility by presenting himself for evaluation to a treatment facility. No formal or written application for evaluation or admission is required. Any person voluntarily seeking admission to a treatment facility must be personally examined and evaluated by a qualified physician of a treatment facility within 24 hours of the time of presenting himself for admission. Such evaluation shall determine whether the person is in need of treatment for mental illness or further psychiatric evaluation by the treatment facility. If the evaluating physician or physicians shall determine that the person is not in need of treatment or further psychiatric evaluation by the treatment facility, the person shall not be accepted as a patient. A written statement from a qualified physician recommending the person

the facility, or that the person will not be benefitted by the treatment available, the person shall not be accepted as a patient. (1973, c. 723, s. 1; c. 1084.)

§ 122-56.4. Voluntary admission to Psychiatric Training and Research Center at North Carolina Memorial Hospital. — Any person believing himself in need of treatment for mental illness or inebriety may voluntarily apply for admission to the Psychiatric Training and Research Center at the South Wing of the North Carolina Memorial Hospital in Chapel Hill in the same manner as he would apply for voluntary admission to any State hospital. Upon approval of his application by the Director of the Inpatient Service, the applicant may be admitted. (1955, c. 1274, s. 2; 1963, c. 1184, s. 2; 1973, c. 723, s. 3; c. 1084.)

§ 122-56.5. Representation of minors and persons adjudicated non compos mentis. — In applying for admission to a treatment facility, in consenting to medical treatment when consent is required, in giving or receiving any legal notice, and in any other legal procedure under this Article, a parent, person standing in loco parentis, or guardian shall act for a minor, and a guardian or trustee shall act for a person adjudicated non compos mentis. (1973, c. 1084.)

§ 122-56.6. Voluntary admission not admissible in involuntary proceeding. — The fact that one has been voluntarily admitted for treatment shall not be competent evidence in an involuntary commitment proceeding. (1973, c. 1084.)

§ 122-57: Repealed by Session Laws 1973, c. 1084.

Revision of Article. — See same catchline under § 122-56.1.

ARTICLE 5.

Admission by Medical Certification.

§ 122-58: Repealed by Session Laws 1973, c. 726, s. 2.

Editor's Note. — Session Laws 1973, c. 723, ratified May 23, 1973, repealed § 122-56, renumbered § 122-57 as 122-59 and created three new sections designated as §§ 122-56, 122-57 and 122-58. The codifier has designated the three new sections as §§ 122-56.1, 122-56.2 and 122-56.3 and has not renumbered § 122-57. Session Laws 1973, c. 726, s. 2, ratified May 23, 1973, repealed §§ 122-58 and 122-59; the codifier has construed this repeal to refer to §§ 122-58 and 122-59 as they appear in Volume 3B of the General Statutes and the 1971 Supplement thereto.

Repealed § 122-58 was amended by Session Laws 1973, c. 673, s. 15.

Stated in Hagins v. Redevelopment Comm'n, 275 N.C. 90, 165 S.E.2d 490 (1969).

ARTICLE 5A.

Involuntary Commitment.

§ 122-58.1. Declaration of policy. — It is the policy of the State that no person shall be committed to a mental health facility unless he is mentally ill or an inebriate and imminently dangerous to himself or others; that a commitment will be accomplished under conditions that protect the dignity and constitutional rights of the person; and that committed persons will be discharged as soon as a less restrictive mode of treatment is appropriate. (1973, c. 726, s. 1; c. 1408, s. 1.)

Revision of Article. — Session Laws 1973, c. 1408, ratified April 12, 1974, and made effective 60 days after ratification, revised and rewrote this article, substituting present §§

122-58.1 through 122-58.18 for former §§ 122-58.1 through 122-58.8. No attempt has been made to point out the changes effected by the revision, but where appropriate, the historical citations to the sections of the former Article have been added to corresponding sections in the Article as revised.

Provisions of Article 5A Applicable to Involuntary Commitment of an Inebriate. — See opinion of Attorney General to Dr. N.P. Zarzar, Division of Mental Health Services, Department of Human Resources, 43 N.C.A.G. 177 (1973).

There is no Minimum Age below Which a Person May Not Be Involuntarily Committed to a North Carolina Treatment Facility under the Provisions of Article 5A, Chapter 122, N.C.G.S., Effective September 1, 1973. — See opinion of Attorney General to Mr. R. G. Frye, Jr., 43 N.C.A.G. 161 (1973).

Eligible Veteran May Be Involuntarily Committed under Article to Veterans' Administration Hospital. — See opinion of Attorney General to Mr. Hal H. Walker, 43 N.C.A.G. 60 (1973). See § 122-58.15.

§ 122-58.2. Definitions. — As used in this Article:

(1) The phrase "dangerous to himself" includes, but is not limited to, those mentally ill or inebriate persons who are unable to provide for their basic needs for food, clothing, or shelter;

(2) The words "inebriety" and "mental illness" have the same meaning as they are given in G.S. 122-36; and

(3) "Law-enforcement officer" means sheriff, deputy sheriff, police officer, and State highway patrolman. (1973, c. 726, s. 1; c. 1408, s. 1.)

§ 122-58.3. Affidavit and petition before clerk or magistrate; custody order. — (a) Any person who has knowledge of a mentally ill or inebriate person who is imminently dangerous to himself or others may appear before a clerk or assistant or deputy clerk of superior court or a magistrate of district court and execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a qualified physician. The affidavit shall include the facts on which the affiant's opinion is based. The respondent must be found in or be a resident of the same county as the clerk or magistrate.

(b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably mentally ill or inebriate and imminently dangerous to himself or others, he shall issue an order to a law-enforcement officer to take the respondent into custody for examination by a qualified physician.

(c) If the clerk or magistrate issues a custody order, he shall also make inquiry, as soon as may be and in any manner deemed reliable, as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.

(d) An affiant who is a qualified physician may execute the oath to the affidavit before any official authorized to administer oaths. He is not required to appear before the clerk or magistrate for this purpose. (1973, c. 726, s. 1; c. 1408, s. 1.)

Physician Who Is Licensed Other Than in North Carolina and Who Is Practicing with Veterans Administration Is "Qualified Physician". — See opinion of Attorney General to Dr. N.P. Zarzar, Division of Mental Health Services, 43 N.C.A.G. 400 (1974), issued under this Article prior to its 1973 revision.

§ 122-58.4. Duties of law-enforcement officer; examination by qualified physician. — (a) Upon receipt of the custody order of the clerk or magistrate, a law-enforcement officer, within 24 hours after the order is signed, shall take the respondent into custody. Immediately upon assuming custody, and in any event within 48 hours, the officer shall take the respondent to a community mental health center for an examination by a qualified physician; if

a qualified physician is not available in the community mental health center, he shall take the respondent to any qualified physician locally available. If a physician is not immediately available, the officer may temporarily detain the respondent in a community mental health facility, if one is available; if such a facility is not available, he may cause the detention of the respondent, under appropriate supervision, in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a regional mental health facility, but not in a jail or other penal facility.

(b) If the affiant who obtained the custody order is a qualified physician, the examination set forth in subsection (a) is not required. In this case, the law-enforcement officer shall take the respondent directly to a mental health facility described in subsection (c).

(c) The qualified physician shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. If the physician finds that the respondent is not mentally ill or an inebriate, or is not imminently dangerous to himself or others, the law-enforcement officer shall release him, and the proceedings shall be terminated. If the physician finds that the respondent is mentally ill or an inebriate, and is imminently dangerous to himself or others, the law-enforcement officer shall take the respondent to a community mental health facility or public or private facility designated or licensed by the Division of Mental Health Services of the Department of Human Resources for temporary custody, observation, and treatment of mentally ill or inebriate persons pending a district court hearing. If there is no community mental health facility so designated, and if the respondent is indigent and unable to pay for his care at a private facility, the law-enforcement officer shall take the respondent to a regional psychiatric facility designated by the Division of Mental Health Services for custody and treatment of the mentally ill and inebriate, and immediately notify the clerk of superior court of his actions.

(d) The findings of the qualified physician and the facts on which they are based, shall be in writing, in all cases. A copy of the findings shall be transmitted to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the physician shall also communicate his findings to the clerk by telephone. (1973, c. 726, s. 1; c. 1408, s. 1.)

§ 122-58.5. Duties of clerk of superior court. — Upon receipt of a qualified physician's finding that a respondent is mentally ill or an inebriate, and imminently dangerous to himself or others, the clerk of superior court shall, upon direction of a district court judge, assign counsel, if necessary, calendar the matter for hearing, and notify the respondent and counsel of the time and place of the hearing. Notice must be given at least 48 hours in advance, unless waived by counsel for the respondent. (1973, c. 1408, s. 1.)

§ 122-58.6. Treatment and release pending hearing. — (a) Within 24 hours of arrival at a community or regional mental health facility described in G.S. 122-58.4(c), the respondent shall be examined by a qualified physician. If the qualified physician finds that the respondent is mentally ill or an inebriate, and is imminently dangerous to himself or others, he shall hold the respondent at the facility pending the district court hearing. If the qualified physician finds that the respondent is not mentally ill or inebriate, or is not imminently dangerous to himself or others, he shall release the respondent pending the district court hearing and so notify the clerk of superior court of the county from which the respondent was sent. Unless the respondent provides his own

'ransportation, the law-enforcement officer shall return the respondent to the originating county. If a respondent, so released, fails, upon proper notification, to attend the hearing, and his presence is not waived by his counsel and the court, he may be taken into custody and returned to the releasing facility by any law-enforcement officer on order of the judge. Days the respondent is on release shall not be counted in computing the 10-day period in which the hearing must be held.

(b) The findings of the qualified physician and the facts on which they are based shall be in writing, in all cases. A copy of the findings shall be transmitted to the clerk of superior court by reliable and expeditious means.

(c) Pending the district court hearing, the qualified physician attending the respondent is authorized to administer to the respondent reasonable and appropriate medication and treatment that is consistent with accepted medical standards. (1973, c. 726, s. 1; c. 1408, s. 1.)

§ 122-58.7. District court hearing. — (a) A hearing shall be held in district court within 10 days of the day the respondent is taken into custody. Upon motion of the respondent's counsel, sufficiently in advance to avoid movement of the respondent, continuances of not more than five days each may be granted.

(b) On order of the presiding judge, the solicitor (district attorney) shall represent the petitioner.

(c) The respondent shall be represented by counsel of his choice, or, if he is indigent within the meaning of G.S. 7A-450, or refuses to retain counsel if financially able to do so, by counsel appointed by the court.

(d) With the consent of the court, counsel may in writing waive the presence of the respondent.

(e) Certified copies of reports and findings of qualified physicians and medical records of the mental health facility are admissible in evidence, but the respondent's right to confront and cross-examine witnesses shall not be denied.

(f) Hearings may be held in an appropriate room not used for treatment of patients at the mental health facility in which the respondent is being treated, if it is located within the judge's judicial district, or in the judge's chambers. A hearing shall not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge, a more suitable place is available.

(g) The hearing shall be closed to the public, unless the respondent requests otherwise.

(h) A copy of all documents admitted and, where applicable, a transcript of oral testimony considered shall be furnished by the clerk to the respondent on request. If the respondent is indigent, the transcript shall be provided at State expense.

(i) To support a commitment order, the court is required to find, by clear, cogent, and convincing evidence, that the respondent is mentally ill or inebriate, and imminently dangerous to himself or others. The court shall record the facts which support its findings. (1973, c. 726, s. 1; c. 1408, s. 1.)

§ 122-58.8. Disposition. — (a) If the court finds that the respondent is not mentally ill or inebriate, or is not imminently dangerous to himself or others, he shall be discharged, and the facility in which he was last a patient so notified.

(b) If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill or inebriate, and is imminently dangerous to himself or others, it may order treatment, inpatient or outpatient, for a period not in excess of 90 days, at a mental health facility, public or private, designated or licensed by the Division of Mental Health Services. Treatment at a private

facility shall be at the expense of the respondent to the extent that such charges are not disposed of by contract between the county and the private facility.

(c) If the court orders outpatient treatment, and the respondent fails to adhere to the prescribed outpatient treatment program, on report of the failure by the chief of medical services of the treatment facility, the court, upon notice to the respondent and his counsel, may order a supplemental hearing, and further order inpatient treatment in a designated or licensed facility for a period of not more than 90 days running from the date of the order. (1973, c. 726, s. 1; 1408, s. 1.)

§ 122-58.9. Appeal. — The judgment of the district court is final. Appeal may be had to the Court of Appeals, on the record, as in civil cases. Appeal does not stay commitment, unless so ordered by the Court of Appeals. The Attorney General shall represent the petitioner on appeal. (1973, c. 726, s. 1; c. 1408, s. 1.)

§ 122-58.10. Duty of assigned counsel; discharge. — Counsel assigned to represent an indigent respondent at the initial district court hearing is also responsible for perfecting and concluding an appeal, if there is one. Upon completion of an appeal, if any, or upon transfer of the respondent to a regional mental health facility, if there is no appeal, assigned counsel is discharged. If the respondent is committed to a community mental health facility, assigned counsel remains responsible for his representation until discharged by order of district court, or until the respondent is unconditionally discharged from the community facility. (1973, c. 1408, s. 1.)

§ 122-58.11. Rehearings. — (a) Fifteen days before the end of the initial treatment period, if the chief of medical services of the inpatient facility determines that treatment of a respondent beyond the initial period will be necessary, he shall so notify the clerk of superior court of the county in which the facility is located. The clerk, at least 10 days before the end of the initial period, on order of a district court judge of the judicial district in which the facility is located, shall calendar the rehearing, shall notify the respondent and his counsel of the time and place of the rehearing.

(b) Rehearings shall be held at the facility in which the respondent is receiving treatment. The judge shall be a judge of the district court of the judicial district in which the facility is located, or a district court judge temporarily assigned to that district.

(c) Rehearings are governed by the same procedures as initial hearings, and the respondent has the same rights he had at the initial hearing, including the right to appeal.

(d) If the court finds that the respondent is not in need of continued hospitalization, or of outpatient care, it shall unconditionally discharge him. A copy of the discharge order shall be furnished by the clerk of superior court of the county of original commitment and the facility from which the respondent is being discharged. If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill or inebriate, and imminently dangerous to himself or others, and in need of continued hospitalization, or, in the alternative, of outpatient care, it may order hospitalization (or outpatient care, as the case may be) for an additional period not in excess of 180 days.

(e) Fifteen days before the end of the second commitment period, and annually thereafter, the chief of medical services of the facility shall review and evaluate the condition of each respondent, and if he determines that a respondent is in continued need of hospitalization or, in the alternative, of outpatient treatment, shall so notify the respondent, his counsel, and the clerk of superior court of

the county in which the facility is located. Unless the respondent through his counsel files with the clerk a written waiver of his right to a rehearing, the clerk, on order of a district court judge of the district in which the facility is located, shall calendar a rehearing for not later than the end of the current commitment period. The procedures and standards for the rehearing are the same as for the first rehearing. Any recommitment ordered shall be for only such period of time as continued treatment is deemed necessary by the chief of medical services of the treatment facility, but in no event longer than one year.

(f) There are no rehearings for outpatients. (1973, c. 726, s. 1; c. 1408, s. 1.)

Actual Notice of Rehearing Required Absent Waiver or Consent to Nonservice. — See opinion of Attorney General to Mr. J. Laird Jacob, Jr., Broughton Hospital, 44 N.C.A.G. 33 (1974).

§ 122-58.12. Counsel for indigents at rehearings. — (a) The senior regular resident superior court judge of a judicial district in which a regional psychiatric facility for the care and treatment of the mentally ill and inebriate is located shall appoint an attorney licensed to practice in North Carolina as special counsel for the mentally ill and inebriate who are indigent. Such special counsel shall serve at the pleasure of the appointing judge, shall not privately practice law, and shall receive annual compensation within the salary range for assistant district attorneys, as fixed by the Administrative Officer of the Courts. It shall be the duty of the special counsel to represent at rehearings under this Article all indigent respondents committed to the facility by a district court judge for mental illness or inebriety, and to represent all indigent respondents who, after a rehearing, appeal to the Court of Appeals. The initial determination of indigency shall be made by the special counsel in accordance with G.S. 7A-450(a), but is subject to redetermination by the presiding judge.

(b) The regional facility shall provide suitable office space for the counsel to meet privately with respondents. The Administrative Office of the Courts shall provide secretarial and clerical service, and necessary equipment and supplies for his office.

(c) In the event of a vacancy in the office of special counsel, or his incapacity, or a conflict of interest, counsel for indigents at rehearings may be assigned by a district judge of the district from among those members of the bar who maintain law offices within 20 miles of the regional facility. Counsel may also be so assigned when, in the opinion of the Administrative Officer of the Courts, the volume of cases warrants. (1973, c. 47, s. 2; c. 1408, s. 1.)

Editor's Note. — Pursuant to Session Laws 1973, c. 47, s. 2, "district attorneys" has been substituted for "solicitors" in subsection (a) as enacted by Session Laws 1973, c. 1408, s. 1.

§ 122-58.13. Release and conditional release. — The chief of medical services of a public or private mental health facility shall discharge a committed respondent unconditionally at any time he determines that the patient is no longer in need of hospitalization. He may also release a respondent conditionally, for periods not in excess of 30 days, on specified medically appropriate conditions. Violation of the conditions is grounds for return to the releasing facility. A law-enforcement officer, on written request of the chief of medical services of the facility, shall take a conditional releasee into custody and return him to the facility. Notice of discharge and of conditional release shall be furnished the clerk of superior court of the county of commitment, and the county in which the facility is located. (1973, c. 726, s. 1; c. 1408, s. 1.)

§ 122-58.14. Transportation. — (a) Transportation of a respondent to or from a clerk or magistrate, a qualified physician, a community mental health facility, and a hearing shall be provided by the city or county, which said

transportation may be by city- or county-owned vehicles, or by private ambulance by contract with the city or county. If the respondent is a resident of a city, the city has the duty to provide the transportation; if the respondent is a resident of a county, outside of city limits, the county has the duty to provide transportation; if a respondent resides outside of the county, the city (or county, as the case may be) in which he is taken into custody has the duty to provide transportation; but cities and counties may contract with each other to accomplish this function. Transportation to or from a regional hospital outside the county, for any purpose, is the responsibility of the county, pursuant to G.S. 122-42. If the respondent is not indigent, the city or county is entitled to recover the costs of transportation from the respondent. A respondent being discharged from a facility may elect to use his own transportation.

(b) To the extent feasible, law-enforcement officers transporting respondents shall dress in plain clothes, and shall travel in unmarked vehicles. (1973, c. 1408, s. 1.)

§ 122-58.15. Commitment of eligible veterans to Veterans Administration facility. — References in this Article to community or regional mental health facilities shall be deemed to include any facility operated by the Veterans Administration for inpatient care and treatment of mentally ill or inebriate veterans. Such a facility may be used for temporary detention pending a district court hearing, and for commitment subsequent to such a hearing. Eligibility of the veteran-respondent for treatment at a Veterans Administration facility, and the availability of space therein, shall be determined in all cases prior to sending or committing a veteran-respondent thereto by filing with the court a certificate of eligibility from the Veterans Administration.

Rehearings for veteran-respondents committed to a Veterans Administration facility shall be held at the facility or at the county courthouse in the county in which the facility is located, and counsel for rehearings shall be assigned from among the members of the bar of the same county. (1973, c. 1408, s. 1.)

§ 122-58.16. Use of community and area mental health facilities. — Directors of community mental health facilities and area mental health programs shall submit for approval by the Division of Mental Health Services, plans consistent with this Article, for maximum utilization of community and area mental health facilities. Such plans shall be formulated after consultation with local court officials and the local medical society. (1973, c. 1408, s. 1.)

§ 122-58.17. Respondents committed under prior law. — Respondents committed to a mental health facility for a specific period of time prior to the effective date of this Article shall be deemed to have been committed, for the same period of time, under this Article. Respondents committed for an indefinite period of time shall be processed under this Article, with the initial district court hearing conducted within 30 days after the effective date of this Article. (1973, c. 1408, s. 1.)

Editor's Note. — Session Laws 1973, c. 1408, ratified April 12, 1974, was made effective 60 days after ratification.

§ 122-58.18. Special emergency procedure for violent persons. — When a person subject to commitment under the provisions of this Article is also violent and requires restraint, and delay in taking him to a qualified physician for examination would likely endanger life or property, a law-enforcement officer may take the person into custody and take him immediately before a magistrate or clerk. The law-enforcement officer shall execute the affidavit

the community, and he cannot be otherwise properly restrained, he may be temporarily hospitalized and treated in a private hospital, county hospital, or other suitable place until a more suitable provision can be made for his care. (1963, c. 1184, s. 2.)

§ 122-65.2. Authorization for admission of patients to Psychiatric Training and Research Center at North Carolina Memorial Hospital. — The Psychiatric Training and Research Center at the South Wing of the North Carolina Memorial Hospital at Chapel Hill shall be authorized to receive alleged mentally ill persons hospitalized for observation and treatment, in the same manner as a State hospital. The clerk of the court shall not, however, hospitalize to this Center without the approval of the Director of the Inpatient Service. (1955, c. 1274, s. 2; 1961, c. 511, s. 6; 1963, c. 1184, s. 2.)

§§ 122-65.3, 122-65.4: Repealed by Session Laws 1973, c. 726, s. 2.

Editor's Note. — Repealed § 122-65.4 was amended by Session Laws 1973, c. 673, s. 19.

§ 122-65.5. Withdrawal of petition. — The petitioner in proceedings to determine whether or not a person is a fit subject for care and treatment in a State hospital may, at any time before the proposed patient has been admitted to the particular State hospital, withdraw such petition by filing with the clerk of the superior court, in writing a motion to this effect. The clerk with the written consent of the examining physicians is authorized to allow such motion. When such motion is allowed, the proceedings shall be deemed at an end. (1945, c. 952, s. 25; 1947, c. 537, s. 16; 1963, c. 1184, s. 2.)

Editor's Note. — The 1963 act inserting this Article designated this section as § 122-66.

Article 7A.

Chronic Alcoholics.

§ 122-65.6. Definitions. — For the purposes of this Article, the following definitions shall apply:

(1) "Chronic alcoholic" shall mean any person who has been found by any court to have the illness or condition known as chronic alcoholism;

(2) "Chronic alcoholism" shall mean the chronic and habitual use of alcoholic beverages by a person to the extent that he has lost the power of self-control with respect to the use of such beverages;

(3) "Court" shall mean either the district or superior court division of the General Court of Justice. (1967, c. 1256, s. 2; 1973, c. 108, s. 77.)

Editor's Note. — The 1973 amendment rewrote subdivision (3), which formerly read: "'Court' shall mean any trial court of this State, except a justice of the peace or mayor's court."

§ 122-65.7. Jurisdiction of trial court over persons acquitted of public drunkenness by reason of chronic alcoholism. — (a) Any court before which a person is acquitted of public drunkenness by reason of chronic alcoholism may retain jurisdiction over such person for purposes of treatment. Upon such acquittal the presiding judge may then take the action authorized by this Article or may order the chronic alcoholic to return to court at a subsequent time before himself or another judge for action to be taken under the authority of this Article. In the event that the chronic alcoholic does not comply with or is not responsive to the action prescribed by the court, the court

APPENDIX J

North Carolina Minimum Standards for Forensic Programming

Subject: New Standards for Forensic Programming
From: Department of Human Resources, Division of Mental Health
For: Community Mental Health Centers of all North Carolina Area Mental Health Programs

Standard 8

The Community Mental Health Center shall facilitate the provision of appropriate services to the criminal justice system and the client within this system.

Factor 1: The CMHC shall facilitate the provision of developmental or psychiatric services to the criminal justice system for their clients.

Factor 2: The CMHC shall work with the appropriate judicial system to develop and designate the center as the portal of entry for forensic clients into the mental health system.

Factor 3: The CMHC shall provide three broad categories of forensic service programming: consultation and education; evaluation and recommendation; and treatment services.

a. Consultation and education services shall include: 1) consultation to those persons (attorneys, judges, etc.) involved in referring alleged offenders to appropriate agencies for pre-trial evaluation, treatment, or rehabilitation. 2) Consultation to those persons involved with the juvenile and adult offenders relative to diversion from the judicial process or from incarceration. 3) Education and training opportunities for other agencies relative to mental health programs, problems, resources and procedures for acquiring services.

b. Evaluation and recommendation services shall include: 1) Pre-trial evaluation of competency to stand trial; 2) Evaluation as to treatment needs as an aid to the judiciary. 3) Pre-sentence evaluation and recommendations when requested by the criminal justice system.

c. Treatment services shall consist of the following components: 1) Outpatient services for both individuals and groups; 2) Inpatient services either at a local designated facility or the Central Forensic Unit at Dorothea Dix Hospital; 3) Emergency services to locally incarcerated clients.

Factor 4: The CMHC shall insure that all forensic services are in compliance with limitation of security required by the court, law enforcement and correctional authorities.

APPENDIX K

The North Carolina Mental Health Association, Inc.

Hospital Evaluation Interview Form

I. While I was in the Psychiatric Hospital:

A. I Feel That The Doctors, Social Workers and Other Attendants:

10	A-1	a)	treated me in a friendly manner
4		b)	were unfriendly at times
		c)	tended always to be unfriendly
6		d)	were usually friendly
1		e)	other
16	A-2	a)	were usually attentive
1		b)	were attentive only when they had to be
1		c)	tended always to be unfriendly
2		d)	were attentive at all times
1		e)	other
8	A-3	a)	carefully explained procedures to me
		b)	avoided making any explanations
6		c)	made explanations when they had to
6		d)	explained when questioned
		e)	other
13	A-4	a)	seemed to understand procedures
		b)	were unsure of procedures
1		c)	avoided carrying out procedures
1		d)	were awkward when helping patients with procedures
		e)	other

B. My Treatment, Medical and Psychological:

9	B-1	a)	was carefully explained
1		b)	was never explained
4		c)	was not explained clearly
		d)	was technically explained as if I were a doctor
2		e)	other
12	B-2	a)	was good for my particular illness
1		b)	could have been given in my home
1		c)	was explained but never carried out
1		d)	was not helpful to me
		e)	other

3 B-3 a) was carried out only by an attendant
b) never saw a doctor
8 c) required the attention of a doctor
1 d) there was no treatment
3 e) other

C. The Time I Would Be In The Hospital Was:

9 C-1 a) carefully explained and I was told why
b) not mentioned
2 c) not explained even when I asked
2 d) changed often without explanation
1 e) other

1 C-2 a) was unrelated to my treatment
9 b) was necessary for me to be treated
2 c) should have been much shorter
1 d) should have been much longer
3 e) other

D. When I Needed To Talk With Someone:

1 D-1 a) neither the doctors nor attendants would listen
15 b) doctors and attendants listened and tried to help
c) I was laughed at by doctors and attendants
1 d) I was listened to, but got no help
1 e) other

E. The Physical Setup of the Hospital Made My Stay:

E-1 a) very uncomfortable because of
1. The beds: hard 1 dirty
2. the food: cold 1 monotonous ___ unavailable 1 tasted bad 8 was spoiled ___
3. the temperature was: too hot 2 too cold 2
4. the hospital clothes I had to wear
5. the lack of comfortable chairs
3 6. nothing to do...no crafts
3 7. no reading materials
6 8. noise & bothersome behavior by other patients.
9. bathroom facilities: dirty ___ poorly ventilated 1 not easily available ___
4 10. I wore my own clothes but they were not kept clean
3 11. no phone
2 12. no writing paper
8 13. no privacy
14. other

a) comfortable because:

13 1. clean
3 2. private
5 3. quiet
10 4. beds comfortable
10 5. food varied, available when needed and tasted good
9 6. telephone available
11 7. I would wear my clothes___they were kept clean 11
13 8. could write letters
11 9. crafts and handwork available
8 10. bathrooms available and clean
7 11. comfortable and attractive furniture in dayrooms.

F. My Family Was:

19 F-1 a) welcomed
1 b) discouraged from visiting
c) not allowed to visit
d) treated rudely
e) other

4 F-2 a) not included in my treatment
10 b) treatment was explained
3 c) did not understand treatment
d) was made to feel necessity for treatment was their fault
3 e) was not allowed to help in treatment

1 F-3 a) was forced on me when I did not want to see them.
b) was not called when I needed them
14 c) was welcome to visit me at anytime
2 d) was never helped to understand how they could help me.
e) other

F-4 My family feels:
14 a) good about the service I received inthe hospital
1 b) resents the way I was treated
2 c) feels the hospital made me worse
d) resents not being helped to understand why I became ill
1 e) other

8 G. If I Become Ill Again:

10 G-1 a) I would willingly return to the hospital
2 b) I would never return to the hospital
c) I feel the hospital made me worse
4 d) I would return to the hospital only if committed

11 G-2 a) I would want to stay home so I could go to the local mental health clinic for help

1 b) I would not want to be treated at the local clinic:

1) because they do not have good doctors and social workers
2) my friends would know it
3) I have no transportation to get there
4) the facilities are not good
5) the doctors and social workers tell my friends what I tell them
6) the cost of treatment at home is too great
6 7) my family would not want it known I was getting help
8) it would be easier for my family to be helped to understand the treatment needed by me.
9) the treatment would be too slow because I could get help only once a week.

H. After Being In The Hospital I Feel:

4 H-1 a) I will never be well
9 b) if I keep up with the treatment recommended by the doctors and social workers, I will get better but not well
c) I will have to return to the hospital frequently
d) the drugs I take make me: sickly___ better_5_ do no good___
e) this is my first visit to the hospital and I will never have to go back
3 f) I feel that I am cured
g) I could have gotten well with no help
11 h) I am well but not because of help given at the hospital.

I. I Went To The Hospital Voluntarily But:

I-1 a) I wanted to leave and was told:

4 1) I could not do so if I wanted to
4 2) I had to get well first
3) I had no legal rights while in the hospital and could not call my lawyer
4) If I left I could never come back

GLOSSARY

Chemotherapy: The use of chemical medications to alleviate of remove symptoms of an impairment of a physical or emotional malfunction.

CHMC: Community Mental Health Center: professional treatment center for mental/emotional disorders principally funded by public monies.

Collateral: person related by blood, law or special significance to a patient or client.

Coping mechanisms: automatic or instinctive and/or consciously directed physical and mental responses to challenging situations in which survival and well-being are at stake.

Forensic: of or pertaint to the courts; legal action; the persons involved with such.

Forensic psychiatry: any involvement of a mental health professional, e.g., psychiatrist, psychologist, social worker, nurse, in the evaluation, testing, and treatment of a respondent, defendant or convicted criminal to assist a judge or jury or prison official in determining the mental status and capacity to undergo trial or incarceration.

Mental retardation: refers to subnormal general intellectual functioning which originates during the development period and is associated with the impairment of either learning and social adjustment or materation, or both.

MMPI: Minneapolis Multiphasic Personality Inventory: a 564-question questionnaire that compares individual results against character traits of previously diagnosed normal and abnormal populations.

Neurosis: contrasted to psychosis, in which one experiences neither gross distortion or misinterpretation of external reality nor gross personality disorganization. A neurotic person is generally aware that his mental/emotional functioning is impaired and desires relief from the symptoms.

Personality disorder: a condition characterized by deeply ingrained maladaptive patterns of behavior that are perceptively different in quality from psychotic and neurotic symptoms. Generally, they are life-ling patterns, often recognizable by the time of adolescence or earlier.

Proactive: basically opposite to reactive; a positive, forward-looking action that prevents system or precess deterioration.

Protocol: a record of the psychological assessments of an individual personality

Psychosis: mental functioning is impaired in so gross a manner that one cannot meet the ordinary demands of life. The impairment may result from a serious distortion of one's capacity to recognize reality; alterations of mood may be so profound that one cannot respond appropriately to external or internal stimuli; decits in perception, language and memory may be so severe that one loses the capacity to mentally grasp a situation.

Schizophrenia: a large category of psychotic disorders manifested by characteristic disturbances of thinking, mood, and behavior.

Transitional Situational Disturbance: any overwhelming stress in the external environment of person, place or thing that an individual cannot cope with in a personally satisfying manner and which causes operational dysfunction or psychic pain.

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